

UNIVERSITY  
MICHIGAN

children

AN INTERDISCIPLINARY JOURNAL



1973



# children

®

VOLUME 3

NUMBER 1

JANUARY-FEBRUARY 1956

DEPOSITED BY THE  
UNITED STATES OF AMERICA

## Socially Deprived Children

I. Therapeutic Work . . . . .	3
<i>Clara Rabinowitz</i>	
II. Helping Their Parents . . . . .	9
<i>Olivia Edwards</i>	
Some Pointers for Professionals . . . . .	13
<i>Letha L. Patterson</i>	
Group Discussion in a Child-Health Conference .	18
<i>Ruth Cumings</i>	
The Meaning of the Maternity Home . . . . .	23
<i>Jane E. Wrieden</i>	
Protective Casework Service . . . . .	27
<i>Lorena Scherer</i>	
A Milestone in Education for Social Work . . .	32
<i>Arlie Johnson</i>	
Book Notes . . . . .	34
Projects and Progress . . . . .	35
Readers' Exchange . . . . .	39

First ingredient in the formula for healthy personality development is a mother's natural expression of love for her child. When this is impaired or distorted by environmental or inner strains the child may face emo-

tional starvation—one of the greatest hazards that can confront a budding personality. Three articles in this issue describe efforts to ward off or combat this danger.

In addition to her part-time work as therapist at New York's Northside Center for Child Development, Clara Rabinowitz carries on a private practice in psychotherapy and serves as a consultant to the staff of the Utopia Day Care Center. Three schools of social work—Pennsylvania, New York, and Smith College—contributed to her training, as did the William Alanson White Institute of Psychiatry and the Washington Institute for Mental Hygiene.



Olivia Edwards has also added considerable postgraduate study, much of it at the New York Psychoanalytic Institute, to the basic professional training in social work she received at the New York School of Social Work, Columbia University. At the Northside Center she serves as therapist for adolescents and for parents of children being treated in the clinic. She also conducts parent-education groups at the center and in nursery schools.



Mother of a mentally retarded child, Letha Patterson, of St. Paul, Minn., is one of the founders of the parents' movement which has resulted in the National Association for Retarded Children and its numerous local and State affiliates. In her continuous efforts to further public understanding of mental retardation she has served as public speaker and lecturer before both professional and lay groups and has written and edited numerous pamphlets.



Ruth Cumings was mental-health consultant in the Westchester County (N. Y.) Health Department when she and six other nurses drew on their experience at the Mamaroneck Health Center to prepare the article on parent-discussion groups on page 18. She is now studying for her doctorate at Teachers College, Columbia University, New York.



Brigadier Jane E. Wrieden, officer in the Salvation Army for over 25 years, received her professional training in social work at the University of Buffalo, School of Social Work. With experience in children's institutions and foster-family programs and in maternity homes and hospitals, she has conducted many institutes on services to unmarried mothers in this country and in Canada.



Casework service to children has occupied Lorena Scherer ever since her first job at the St. Louis Training School for Feeble Minded Children back in the early Thirties. Before going to the Missouri Division of Welfare in 1938, first as a regional child welfare supervisor, she was with the Board of Children's Guardians in St. Louis. She attended the New York School of Social Work and the School of Social Work, Washington University, St. Louis.



## ◀ the authors

### *National Advisers to CHILDREN*

Walter A. Adams, M. D.  
Philip S. Barba, M. D.  
Mrs. Sara Ricks Caldwell, M. S.  
Ruth Gilbert, M. A.  
Boyd McCandless, Ph. D.  
Lucy Morgan, Ph. D.  
John L. Parks, M. D.  
Helen H. Perlman, M. S.  
Helen Ross  
Edward Schlesinger, M. D.  
Eugene J. Taylor, M. S.  
Julius J. Teller, J. U. D.

### *Editorial Advisory Board:*

Gertrude Church, M. A.  
*Nursing, Chairman*  
Katherine Bain, M. D.  
*Pediatrics*  
Edith Baker, M. S. W.  
*Medical Social Work*  
Elizabeth Herzog  
*Social Sciences*  
Alice Scott Hyatt, M. S.  
*Social Administration*  
Elliott Studt, M. S. W.  
*Social Work*

### *Editor:*

Kathryn Close

### *Art Editor:*

Philip Bonn



# SOCIALLY DEPRIVED CHILDREN

## I. THERAPEUTIC WORK

CLARA RABINOWITZ, M. S.

*Psychotherapist, Northside Center for Child Development, New York*

HV  
741  
A362

SEVERAL TYPES of children are accepted with reluctance by many psychiatric clinics: the delinquent, the retarded, the schizophrenic, and the child who lives under base social and economic conditions. This article is concerned with the children requiring treatment and living under submarginal conditions. It has these objectives: first, to encourage wider exploration of the relatedness between the variables in personality and in the social and economic backgrounds of children; second, to consider whether children living under submarginal social conditions can be helped psychiatrically; third, to examine some problems which arise in therapeutic work with such children.

In the preparation of this paper, the clinic records of a group of children known to the Northside Center for Child Development in New York City have been reviewed. These children are not typical of the clinic population, which is of varied background. Their records were chosen for review because they have all lived under grave social and economic conditions such as bad housing in slum areas, overcrowding, inadequate clothing, insufficient medical care, no personal possessions or spending money; strained, quarrelsome home atmospheres. Some are latchkey children. Most of them attend poor schools. Reviewed together their case records reveal a number of similar therapeutic problems.

The following three summaries are greatly telescoped:

### *Martin*

Martin is the only son among four children. The irregularity of his father's work as a longshoreman forced the family to recurrent applications for relief. The mother responded to the frequent changes in eco-

nomic status from subsistence level to something less with feelings of humiliation.

The father was asthmatic. Periodically he fled his troubles and responsibilities through weekend drinking bouts with men friends. The mother was depressed and enraged because of the poverty and the limitations it created for the children.

Martin was referred to the clinic because he could not learn to read or write even in a class for slow

One of the outstanding trends revealed at the 1955 meeting of the American Orthopsychiatric Association was an awakened interest in extending therapeutic services to those groups of children too long rejected by many child-guidance and social-casework agencies as not amenable to treatment—especially children from socially and economically deprived areas. The two papers presented in these opening pages, which were part of a symposium on the subject, describe the way one voluntary agency is attempting to adjust its therapeutic techniques to meet the impact of social malignancy on children, parents, and therapist. They are evidence, along with Lorena Scherer's article on protective casework on page 18, of social work's growing determination to reach out and persist rather than to give up in the face of "resistance."

learners, and because he would fall asleep in school after long periods of reverie. The clinic physician found the boy to be more than 12 pounds underweight. Psychological testing indicated that his inability to concentrate interfered with full use of his capacities as a dull-normal child. His characteristic way of coping with anxiety or conflict was avoidance. The psychiatric history suggested that Martin's asthmatic condition since infancy, in a home of very few material resources, might have made of him a "cherished nuisance." It also indicated that the attention he had had as a sick child, and the mother's later restriction of his social life because of the hazards in the slum neighborhood, might have contributed to his very dependent, distant, and uncommunicative behavior. The clinic's tentative diagnosis, before therapy, was "neurotic character disorder in a chronically ill boy." Remedial reading work was recommended along with therapy.

Despite Martin's inability to volunteer anything for the first 6 months of therapy, the clinic continued to work with him from the time he was 12 until he was 14½ years old. Because neither parent participated actively in these efforts (the mother refused contact after several interviews in the clinic and in her home), the therapist was left with a technical problem of how to understand and how to give Martin a basis for understanding his periods of serious depression. She had to choose between drawing mainly upon her knowledge and experience about nonverbal people, and utilizing the very meager data about his family life in the record as a basis for her procedure. Feeling that she knew too little about the interaction in the home, and fearing to risk reactive upset in the boy, which might impel the suspicious mother to remove him from the clinic precipitously, she relied chiefly on her general knowledge about very aloof, uncommunicative people. The other course would have been to tackle, in language understandable to Martin, the dynamics of his response to a distant but overprotective mother and an escapist father who left him without support in coping with his own problems.

### *Ann*

The case of Ann is still in process after 2 years. Referred by a public agency for youth, Ann, an obese but otherwise good-looking Negro girl of 14, was nervous, stuttered, and resorted to screaming when provoked. She was in the eighth grade and falling behind. Tests pointed to intellectual capacities significantly above her achievements.

The psychiatric consultant, coordinating all the data, noted that "it is difficult to separate the overwhelming reality problems from the psychological difficulties in Ann's problem in living. . . . Ann's minimizing her problems may be an example of the mechanisms of denial, but on the other hand, denial to some degree may be a necessary maneuver under such stress. [All of the symptoms] point in the direction of neurotic mechanisms which may be hindering Ann from coping fully with the severe deprivation she must deal with." The diagnosis and differential diagnosis were: (1) neurotic reaction to severe deprivation; (2) situational reaction to severe deprivation.

The eldest of eight children, Ann lived with her parents and siblings and another family of seven—altogether 16 other people—in four very substandard rooms. She had no possessions and no place to study or to store schoolbooks or her very insufficient clothes. Her parents cared a great deal about her but were too restrictive about association with boys and about allowing her to meet her peers on the street, as was the custom on the block. In a limited clinic contact, the father, an unskilled worker whose income was supplemented by public assistance, appeared discouraged for himself and the family. The mother, visited in the home when she stopped coming to the clinic, appeared lethargic, almost too accepting of her situation. At the same time, she resented the lack of necessities for her home and children.

Because of Ann's very real material needs, much of the therapist's time during the interviews was devoted to doing concrete things for her; and when the family life became even more complicated (the father deserting and the mother becoming hospitalized for tuberculosis), the therapist had to assume even greater responsibilities. As Ann and the therapist became more deeply acquainted, therapeutic goals evolved. The first was to help the girl to become aware of her terrible resentment at her degrading life situation. The purpose of this was not so much to "release anger" as to establish a reality basis for her hurt, as distinguished from the attacks on her self-esteem she felt from teachers, friends, and others when no hurt was intended by them. Another goal was to clarify her distorted views of the relations between men and women, about marriage and about responsibilities among grownups, and to show her how these views had developed from her experience in the two families with whom she had grown up and how they contributed to her irrational anger. She had to become aware, too, of her covert,

destructive maneuvers with her peers. The therapist had to risk Ann's open anger against her parents even though she knew how little Ann had beyond her relationship with them.

In her efforts the therapist was very often overwhelmed with discouragement for herself and for the girl, feeling that she could not do enough to matter, and that Ann already had too many real responsibilities to be able to bear any anxiety that accompanied the therapy.

### Matthew

A school nurse sent Matthew, aged 11, and his mother to the clinic. Matt was seventh of eight children. He could not learn to read and was having to repeat grades. His mother was resentful of her husband, who was much older than she, because he remained retired from the Navy although his pension was too small to provide basic family necessities and because he did not participate in the family life. Her apathy made her appear intellectually limited. She was very restrictive and punitive with the children in her effort to keep them out of trouble.

Matt was seen in the psychological study as a child of average intelligence, functioning at the level of a 6-year-old and relating to adults with dependence, helplessness, and great aloofness. The diagnosis was "severe neurotic disorder with possible schizophrenia"; the prognosis was guarded.

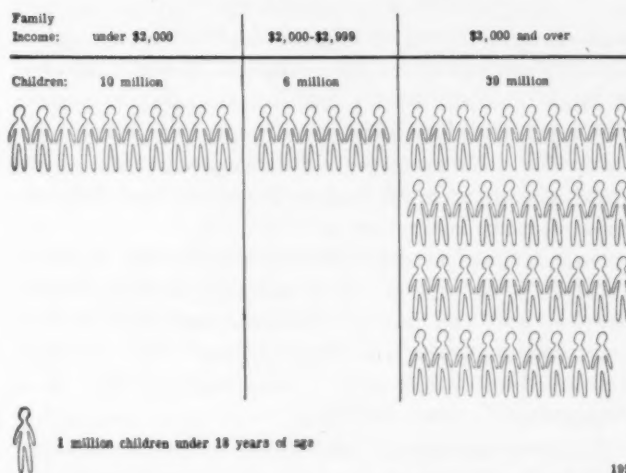
The therapist, finding no indication of change after many interviews, requested psychological retesting to check for possible intellectual retardation. In the next few months Matt began to participate in games more appropriate for his age. However, the original diagnostic impression remained after 10 months of therapy. After a summer break, Matt returned to the clinic more alive and acting more his age. He continued to function on an increasingly higher level. He also began to show improvement in reading and in school work generally. After 48 interviews in a total of 21 months, therapy was discontinued as both therapist and Matt were satisfied that he could carry on and continue to grow. Matthew's mother also responded well to her experience with the social worker.

### Problems of Deprivation

In all these cases the therapist was faced with problems arising from the child's deprivation.

First, there was the problem of the interpersonal connection between child patient and therapist. Work with these troubled children often evokes in

## CHILDREN AND FAMILY INCOME



More than a sixth of the Nation's children are in families with total incomes of less than \$2,000 a year, nearly a third in families having \$3,000 a year or less. When economic strain is severe, family relationships are often adversely affected.

the therapist such strong feelings of sympathy as to arouse an overprotective attitude. At the same time, the child's frustration may overwhelm the therapist with hopelessness about being able to assist him.

Another aspect of the interaction is more creative. It is the positive aura which springs from love for him and pain for his suffering and so cannot fail to communicate itself to the child. Not only is this imperative to the therapy but it offers the child an experience which he has seldom been able to get from the significant adults in his life because of their preoccupation with their own burdens and with a sense of failure.

The therapist's feelings may interfere in the therapeutic process with these children as they may in any other psychological work. Therefore she must constantly criticize her own role in order to correct her perception of the data as it emerges. For example, when Ann continued to distort the motives and actions of others and to view her improved, although still undesirable, situation with the same old bitterness, the therapist could recover from her immediate response to Ann's depression and see that the girl was persisting in dealing with a new environment as if it were the old.

Similarly, when Martin continued to deal with the therapist in the same aloof way as when they were comparative strangers, the therapist, at first feeling that this child could do no better because too little had been done for him, was able to become aware



that in the therapy, a truly new situation, Martin was acting as if it were an old one and in this way was clinging to the familiar, destructive though it was. Then the therapist could point out that even if Martin's total reality had not changed, he was in this quite different relationship not returning anything for value received. This approach offered the child the chance of learning something different about human interchange.

So it is that the task of the therapist with deprived children is to steer a course between enough identification and too much. Nevertheless, an involvement in the child's life of great deprivation is mandatory. One cannot remain detached and help these youngsters therapeutically.

Another serious barrier which arises in working with such children is that the therapist must often work in the dark. This is true when parents are unable or unwilling to participate in the treatment. It is especially defeating for children too young to tell about their experiences, or incapable of verbalizing.

One may ask why a clinic would undertake to work with children whose responsible relatives do not collaborate. In our clinic such cases usually have begun with participation on the part of some responsible adult, who, as in the case of Martin, has withdrawn from contact after the child has become involved. Perhaps it would seem wiser to present such parents with the alternative of giving up clinic service for the child. However, our view has been that if the children themselves are benefiting from the therapy, it would be double hurt to drop them when they cannot be treated in the usual manner.

Nevertheless, the disadvantages created by the nonparticipation of a parent are not to be denied. We not only miss the opportunity for the kind of clarification with the child which comes from knowing the environmental events precipitating his changes in feeling and behavior, but the therapy loses the force derived from the parents' interaction with the clinic. The therapist is especially handicapped in being unable to evaluate, with any degree of accuracy, the mental status of the parents with whom the child is interacting. When the clinic has the aid of an adult informant the therapist is on more solid ground in building a view of the reality of the child's life and his way of coping with it.

For example, in dealing with the possible sources of Martin's depression, the therapist had to choose between leaning on theory or on the too meager facts known about his situational and interpersonal reality.

The therapist chose to lean toward theoretical understanding about why and how children become depressed. This led to too much abstractness and too little introduction about events in Martin's life and about his misinterpretations concerning them. Such an error is too easy to make when data is not available from direct contact with significant adults in the child's life. The necessity for a strong and mobile casework program in a clinic is apparent.

### *The Parents*

Several factors must be considered in respect to the behavior of socially deprived parents toward their children. Often they do not show love in conventional terms. However, their behavior with their children does not seem to reflect rejection or lack of love or of concern. Many of these parents have all but lost any motivation to change even the material aspects of their lives. Some have lapsed into passive acceptance of uncertain income and coauthority over the purse strings with public-assistance officials. More have grown bitter and to hate their lot and the people they believe associated with it. They have little energy left for any open show of tenderness to their children.

These parents express deep devotion for their children, but they do this in terms of how they must struggle to provide the barest essentials for the child. They express their love through their anger and unhappiness in not being able providers. Feeling that they must protect their children from the dangers inherent in slum life, they are often extremely restrictive. Thus they prohibit contact with the opposite sex, street play, or attendance at any but the closest play centers. Thus they are often harsh disciplinarians in an effort to ward off delinquency and to strive for decency in their children. While such parental attitudes often create in the children feelings of not being loved, we therapists must also see in these attitudes the struggle in the parents for something good.

Since they feel that they are doing all that *they* are capable of doing for their children and are too burdened by care to reach out for change, these parents require much stimulation from the outside. They come to the clinic with a kind of depressive, sometimes apathetic, immobility, leaving the clinic to carry for a long while the burden of the struggle for change.

The ordinary interviewing techniques alone are insufficient to motivate these parents to change. The



clinic's degree of expertness in working directly with the child and its willingness to be available to and to assume responsibility for at least the early months of contact with the parents, are positive determinants for such motivation.

A further point of difficulty in work with children of submarginal backgrounds is loss of the cushioning effects of community resources available to children of families with more economic leeway. Here enter the problems of too little clothing, no money for carfare to go places or to call the clinic, limitations in general knowledge, insufficient encouragement from others. Without material aids such as camp, outings, clubs, parties, petty cash, clothes, special classes, the therapeutic changes in the child often have little chance of becoming consolidated.

Since the therapist more often than not comes from a different economic class than these children or their parents, she may be dependent upon some material things that they have never known or depended on. Thus, she must always make an effort to see whether her conventional view interferes with a correct understanding of a child's response to his reality. This is not the same as "adjusting" to the child's deprivation.

### ***Modified Practices***

At our clinic we have learned to modify theory and practice in order to work with children who are deprived in so many ways.

First, and foremost, stands the clinic's readiness and willingness to use its services for children who will tax its resources to a much greater degree than other children.

Next, we have learned that a parent's reluctance to use psychiatric help when he reaches the clinic on referral may be associated with great inertia and depression arising from feelings of rejection by society. When we meet the parent with an understanding about this he may be more able to use deep psychiatric help. This raises a question about the psychiatric conception of "the self-determination of the client"—whether or not a clinic's efforts to break down a parent's reluctance to treatment for himself or his child is a violation of his freedom of choice. Where sick children and apathetic parents are concerned, the clinic would seem to have a responsibility to engage in a struggle with parents, with the goal of helping them to pull away from their apathy. This is not to imply that psychiatric services must force their help upon apathetic applicants. It merely means that apathy can exist on both sides.

Another result of our experience is in respect to

psychiatric diagnosis. In assessing the strengths which therapy may count on in the child's personality, we have to make allowance for the dulling influence which the environment and the parent's restrictions may produce. Children like Matthew and Martin appear gravely ill, possibly to be undergoing an active schizophrenic process. We have learned, however, that reality factors may produce a similar effect. In Matthew's case, the malevolent process was reversed through treatment. Although Martin did not change so markedly, there was sufficient intrusion of a different kind of reality experience, via the therapy, to make this aloof, seemingly inanimate child, respond more openly to others, on a less special and less dependent basis. It also made it possible for him to look forward to new and hopeful experiences, such as attending a trade high school, with hope and pleasure.

A still different aspect of our dealing realistically with the child's realities is to accept his complaints and explanations, such as inability to compete socially because of insufficient clothes or irritability due to lack of privacy as facts and not as resistance. Our acceptance permits the child to know that we respect his view and understand his situation. At the same time, we attend to sifting out the real from the unreal, thereby coming to distinguish the child's distorted generalizations from his experience.

We have also learned to continue working with the child if he moves into any degree of relationship with the therapist even when the usual aids to therapy are absent, and when there is no responsible adult having regular clinic contacts. We continue despite the gaps in such aids, knowing that our work will be slower and more difficult for patient and therapist.

### ***Sustaining Forces***

In such instances, the immediately sustaining forces for the therapist are:

1. The growing relationship between therapist and the child. In this relationship the child is increasingly aware of the therapist as a friend who is trying to discover the truth with him and the therapist is aware of the child as a person who is earnestly seeking the truth for himself.

2. The reliance on theory and experience. This enables the therapist to look for a pattern in the child's behavior with others (in these instances, mainly his behavior with the therapist) which is most characteristic of the misinterpretations. It also enables the therapist to present the child with a different

view of himself than the confused self-image he has. This process of picking up the child's characteristic difficulties, of helping him to understand their source (when the child is old enough for this), and of helping him to see how he defeats himself and what a poor view he has of himself is backed up by the therapist's conception of the child as he would appear if stripped of his handicapping distortions. The contrast between the therapist's "good" view and the child's poor self-image becomes the therapeutic focus in the struggle for change.

We have also learned that it is sometimes necessary to intervene in the realities of the children's lives. As Dr. Augusta Bonnard of London has said in an informal communication to a colleague, "... therapy for a hungry or grossly deprived child is a bad joke—and the child will feel it is being made a fool of. Hungry children must be fed, even in a child-guidance clinic . . ."

Recognition of the environmental reality with its potential for influencing the personality must be accompanied by recognition of the psychological reality which the child experiences in his interpersonal relations with significant adults. Because in Martin's case specific information about the family's interpersonal relations was not available in sufficient detail, it was necessary to theorize about it.

With Ann, it was necessary and possible to be explicit about the force of life history (her parents' poverty and their efforts to create a different life by their marriage, even if at too early age) in considering what she regarded as her parents' peculiar behavior and how this had greatly determined her own unique distortions about other people. Making such direct connections relieves the child of guilt about his articulated or unspoken criticism of a parent. At the same time, it takes away the onus of wilfulness in a parent's hurting a child. It helped Ann to feel more affection for her mother and pride for her striving to hold the family together. While it could not help Ann to love a father who broke down under the weight of so much responsibility, it did help her to express directly her disappointment, hurt, and disgust. She began to differentiate her view of her father from her observations about boys she was now meeting. Ultimately, she felt she was meeting and

having fun with male compeers without feeling ill at ease or exploited.

### *Goals and Chances*

Working with mentally ill children from socially and economically submarginal environments poses the problem of goals as does any other psychological activity. If infants all were born into equally adequate external conditions and had equally sound health they would have infinite possibility for creative use of themselves. When optimal conditions for growth do not obtain, some damage is likely to occur. We, as their therapists, can only try to release the greatest degree of capacity possible within the time and skill at our command and within the children's limits.

A general goal is to enable the child patient to want to master more aptly whatever exists in his environment that may help him become more independent—school, friends, or recreational opportunities—and to find constructive ways of getting, or at least showing a need of, the material things he requires.

A combination of a seriously substandard environment plus grave family disorganization is conducive to serious disorganization in the personality. The child who comes from a family where there is a semblance of interpersonal unity and organization and an ordinary amount of love expressed in emotional terms has a better chance of being helped by therapy than the child from a home without these advantages. So has the child in whose behalf some responsible adult will collaborate with the clinic.

It follows that a child not yet old enough to verbalize his problems or to have some experience independent of the home has less chance of getting enough help when the realities of his life are unwholesome and when he attends the clinic without an adult.

Nevertheless, given flexibility in therapeutic method and the willingness of clinics to serve them, many children who suffer the combined conditions of mental illness and grave social deprivation can be treated psychiatrically. The greatest aids to the clinic in these efforts are the qualities of human resilience and desire to live which the children and their parents bring with them, however shrouded these may be in the beginning.

# SOCIALLY DEPRIVED CHILDREN

## II. HELPING THEIR PARENTS

OLIVIA EDWARDS, M. S.

*Psychiatric Social Worker, Northside Center for Child Development, New York*

**P**ARENTS who have had to use their energies fighting for existence amidst malignant social conditions are often too worn down and involved in this struggle to enter into any intensive and intricate examination of themselves or their relationships to their children.

Yet our experience at the Northside Center for Child Development has shown that success in treatment of children from deprived social backgrounds depends to a great extent on how much their parents can also be involved in treatment. It has also shown that for such children and their parents approaches which deviate from the usual clinical approach are required.

The caseworker's usual methods of focusing on neurotic patterns of behavior in parents in order to effect some changes in their attitude and behavior is an important and proper part of his functioning in a child-guidance clinic. However, there are some people for which these methods, by themselves, do not work, such as those from deprived families.

As psychiatric casework developed from the material-giving, sympathy-giving approach to the use of psychodynamics, an older form of treatment once used successfully has been more and more neglected. I refer to an emphasis on the environment, the first area in which the caseworker assumed his professional role. Dr. Irene M. Josselyn has pointed out: "With the recognition of the effect of the impact of the environment upon the individual, it became apparent that if the environment were modified, the individual's pattern of behavior might also be modified. Children were removed from undesirable homes and schools, adults were helped to find congenial jobs and adequate recreation, and disturbed individuals were protected from excessive pressure from reality as they struggled with their internal

conflicts. The results in many cases were, and continue to be, excellent."<sup>1</sup> An adapted use of this older form of working is pertinent for deprived families.

### *Environmental Help*

We found an application of this approach useful in our attempts to help Mrs. R., a Negro mother, who despite physical and financial hardships, managed to move her family (consisting of her husband and five children) from a sharecropper's farm in a southern State to a crowded tenement neighborhood in New York City. She had been referred to our clinic for help for the youngest son, Jim, who was a problem in school in that he would not protect himself against the aggressiveness of other children, ran out of his classroom whenever scolded by the teacher, and was fearful at home.

At this time both parents and children in Mrs. R.'s family were being treated for syphilitic illnesses, one daughter had a malignant lung condition, and one daughter suffered from rheumatic heart disease. The father's earnings had to be supplemented by public assistance. As time passed the two older boys became narcotic addicts; one was arrested and imprisoned for breaking into a store; the other made an immature marriage; Mrs. R. was operated on for a tumor on her larynx and subsequently lost full use of her voice so she could not speak above a whisper.

This family of seven lived in two small rooms on the top floor of a badly kept boardinghouse. On becoming acquainted with Mrs. R. the caseworker was made immediately aware of her deep hostilities which had grown up out of many bad experiences in the South, but which she easily transferred to all people in authority with whom she came in contact.

It is obvious that Mrs. R. needed all the support,



all the identification, all the attention a caseworker could give her. This seemed the only sensible way in which to maintain her interest in coming to the clinic. This does not mean the worker sat down and cried with Mrs. R. about her troubles; rather she became actively involved in helping her to deal with housing authorities, welfare investigators, narcotics experts, police officials, health agencies, and the like. While this was going on it would have been devastating to Mrs. R. to attempt to help her face an additional burden—knowledge that she had contributed to her children's inability to adjust to the pressures and temptations of a new environment and had contributed to Jim's anxieties and poor relationships with other children and teachers.

The caseworker had to set aside her own fears that Mrs. R. would become too dependent. As she accepted the necessity of giving Mrs. R. moral support and of actively helping her in her dealings with people in authority, a relationship developed between them. Mrs. R. could begin to understand and digest the caseworker's little remarks about the effect of her anxieties, hostilities and fears on her child and to consider how her domination of her family played a part in the deterioration of the older boys.

Because of this relationship, in which the caseworker used an active supportive role as a conscious technique, Mrs. R. was able to try out the caseworker's direct suggestions for dealing with the realities of her environmental problems. Finally, as she became free of many of her hostile feelings toward herself and toward others, Mrs. R. accepted her right to disassociate herself to some extent from the problems of her grown children, to absolve herself of responsibility for their behavior and to begin to have some life for herself.

Because Mrs. R. came to the clinic in dire need for help with problems based on a breakdown in economic, environmental, and health factors, these reality needs were given priority in the treatment relationship. She was thus motivated to continue her appointments.

Mrs. R. had been a leader in her southern community, had good native intellectual ability and had participated fully in the social and political life around her. She had personality assets which had carried her through past hardships and which were revived as she was helped with the new kind of hardships arising out of her new environment.

But there are other clients whose economic deprivation is compounded by other problems which make them even more difficult to reach. These are

people who seemingly have less native endowment, who have led isolated lives and who have been unrelated to the wider community activities around them. Living constricted, socially unaware existences they usually do not come to the clinic of their own volition but only after persuasion or in response to demands of referring agencies, who represent to them authorities whom they must obey.

### *The Isolated*

Mrs. A. is a mother who is apparently limited intellectually. She had been sent to a hospital mental-hygiene clinic with her daughter, a nervous, jumpy child, after the little girl cut off some of her hair. This clinic had given the daughter diagnostic tests and referred her to Northside Center for therapy. Mrs. A's chief concern was about her daughter's hair and throughout the clinic's contact with her she held to the belief that the child, who was being seen by the therapist once a week, was in some mysterious way getting treatment for her hair.

The caseworker who saw Mrs. A. once a week encouraged her to express her ideas about things as simple as the color scheme she would choose for a new outfit of clothing. This interest and acceptance gave Mrs. A. a feeling of self-worth. When the caseworker told her about plays for parents and children being presented by a local "Y," she began attending these with her little girl. Then, at the caseworker's suggestion, she enrolled her daughter in the Girl Scouts.

Using the relationship developed with Mrs. A. as the result of these tangibles, the caseworker discussed the daughter's need for some independence—for encouragement to express herself as Mrs. A. had gained encouragement for self-expression from the caseworker. The caseworker also helped Mrs. A. to reach a point where she could tell her daughter about her illegitimacy and why her father could not live with them, although he came to visit and contributed toward her support. She thus was helped to dispel the child's distorted ideas about sex and the father's role in the family and to modify much of her own feeling of guilt. Work in this case was limited, but Mrs. A. and her daughter left the clinic with a better sense of their own value and a better emotional connection between them.

### *Matt's Mother*

The worker who saw Mrs. S., mother of Matt, described by Miss Rabinowitz, contributed to the therapist's success in working with him by her ability to



involve Mrs. S. in the treatment process. Burdened by financial problems, a disinterested husband, and a large family, Mrs. S. had an extremely limited social life. On the defensive and reluctant to admit to any difficulty in handling her children, she practiced strict control over them. However, she saw Matt's need for remedial reading and on this basis sent him to the clinic. She kept appointments at first out of her great respect for authority but without the least idea of changing her relationship to her child.

The caseworker maintained this mother's interest by arranging for Matt to attend the clinic free of charge and by getting him a bus pass for this purpose—thus recognizing her limited financial resources—and by accepting her need to accompany Matt thru “the dangerous neighborhood” to the clinic. In the second interview when Mrs. S. apologized about discussing the family's troubles, the caseworker said, “This is a very real worry with prices going up,” thus setting the stage for attention to Mrs. S.'s practical problems and encouraging her to come regularly for appointments. Despite the limitations of the discussions due to Mrs. S.'s lack of spontaneity, her constricted personality, and her isolated life experiences, the worker persisted in seeing her. She realized that Mrs. S. needed a person with authority who would listen to her with respect and who could accept her childlike, dependent way of responding.

Work with Mrs. S. was halting, elusive, tenuous, but worthwhile. Once when the caseworker suggested that Mrs. S. might resent being told what to do about Matt, Mrs. S. replied, “No—you are helpful and I try to do as you say; I know it's to make things easier for me, and the children gain from it.”

In order to help Mrs. S. feel more comfortable in social contacts, the clinic invited her to join a group of five mothers who met once a month with one of the social workers. This group had been started as a device to offer some of the socially compressed parents an opportunity for more human contact, for interchanging ideas and experiences. The group, appropriately named The Social Group by one of the mothers, blossomed into a verbal, active “club.” The mothers had relatively animated discussions about themselves and their families, and once had a party.

On two occasions the social worker took the group to museums and once to a downtown show—an entirely new experience for them. It is difficult to describe their feelings of discovery and happiness. The theatergoing and contact with the group was an important factor in opening up a new side of the

world for Mrs. S.; it enabled her to feel closer to the caseworker, who had brought these things into her life. Mrs. S. was therefore able to verbalize some of her deeper feelings.

Gradually Mrs. S. softened toward her children. At the end of 23 sessions, the worker observed of her: “Her world was very small and her contact at Northside Center has widened it for her and helped her change somewhat in relation to the children.” Direct suggestions had been made to her concerning her handling of her children, and she had had enough confidence in the caseworker to try to follow through on these suggestions. Her experience in the social group had made such an impression on her that after her contact at the clinic ceased she joined a community recreation center.

The effect of the total clinic contact was good for Matt. His most striking behavior characteristic, which was to act like a defective child—although he rated average intellectual ability on tests—showed marked symptomatic improvement after 48 sessions. He became a less constricted, happier boy and in his relationship with his mother developed some ability to choose.

### *A Combined Role*

In the last two cases, the worker's approach was limited to staying with the mothers at the level and pace they set—similar to the way in which the therapist accepted Martin's slow and irregular pace, as described by Miss Rabinowitz. These parents could not be hurried, nor could they digest more than simple suggestions. Yet, they seemed to emerge happier and more aware of their children as individuals.

We cannot overlook the fact that to hold oneself to the psychological limits set by a Mrs. R. or a Mrs. S. calls for infinite patience on the part of the caseworker as she sits through slow-moving and repetitive interviews. The kind of “reaching out” described in Mrs. R.'s case involves visits to the home, the school, the hospital, and other agencies. Often these parents are too hostile—because of having had many disappointing experiences with schools, hospitals, police—to understand how these agencies want to help. The caseworker has to step in as the parent's representative until she has been able to help them to approach these agencies with more positive attitudes. In situation after situation she teaches the parent through example to develop such attitudes.

The supportive role of the caseworker is most important when working with adolescents. Many ado-

lescents develop hostile, fighting-back, oppositional defenses against the deprivations in their lives. They are not in the mood for treatment based on self-examination and see only the unfairness of their life situations with all the frustrations involved.

Miss Rabinowitz has pointed to the necessity in some cases of intervening in the realities. The caseworker is often in a more fortunate position for this than the therapist, since she works in the clinic on a full-time basis rather than by the hour as the therapist does. Moreover, by tradition, and often by inclination, the caseworker is more apt to accept the role of part therapist, part big sister, part helpful and sympathetic authority for the adolescent. This involves, in addition to office interviews, going out on trips with clients and on visits to home and school. In some cases, the adolescent begins to imitate the caseworker's social behavior, accepts her as a real friend and borrows her ego strengths.

It is true that these approaches add to the pressures of a caseworker's job and require a decision to be made as to how much time can realistically be put into this type of service.

It seems to me that enough important and lasting gains came from the physical as well as mental efforts put forth by the caseworker in the cases described here to warrant sincere consideration of the efficacy of this kind of work in helping people. We have to reexamine our own attitude and feelings about doing this kind of job. We have to be aware of our own readiness to reject what may seem to be the more lowly task of offering tangible help which is the only kind of help to which some people are ready to respond when they come to the clinic.

In a psychiatric clinic, where the major function is to practice dynamic, insight-developing, psychiatric casework, it is possible to work with cases which at first seem hopeless because of the grave all-around deprivations, if we are willing to consider the social aspects of our job along with the psychiatric aspects. Dr. Sol Ginsburg recognized the psychiatric worker's conflict in this respect when he wrote:

"We have been hampered by the erroneous prestige which has come to be associated with dynamic ther-

apy as opposed to what seems to be looked upon as the more humble desire and skill of 'merely' helping people. . . . At a case presentation made jointly by a psychoanalyst and two social workers, the accusation was made that they were too identified with the patient and hence overprotective and even 'loving.' The patient was a badly neglected, utterly deprived child, and it seemed to me that a perfectly adequate theoretical case could have been constructed for the techniques employed. But what interested me more was the need of several of those who participated in the discussion to find some technical justification for such feelings, some sanction for them in dynamic terms, as if just loving the child was somehow suspect."<sup>2</sup>

### *In summary*

Although our chief mode of operating our child-guidance clinic is through the use of insight and interpretative therapy, we have found that some very deprived people require a supportive environmental approach to encourage them to a more constructive view of themselves. Sometimes this becomes the goal of help and sometimes it is combined with efforts to achieve direct insight. Sometimes it is preliminary to a more intensive psychiatric approach.

This supportive approach involves a conscious use by the worker of self and aids in helping the client to cope with his environmental pressures. It differs from the practice of giving help in the Lady Bountiful days of social work, inasmuch as it takes into consideration the psychological needs and drives of the client. The caseworker helps the client to develop as much insight as possible into his neurotic patterns, but does so through lending active help in many troublesome and frustrating experiences. Always the worker aims to help the individual become a more integrated person who will be assuming increasing responsibility for his behavior towards others and himself.

<sup>1</sup> Josselyn, Irene M.: *Psychosocial development of children*. New York: Family Service Association, 1948.

<sup>2</sup> Ginsburg, Sol: The impact of the social worker's cultural structure on social therapy. *Journal of Social Casework* 32: 319-325, October 1951.

## SOME POINTERS FOR PROFESSIONALS

LETHA L. PATTERSON

*Member, National Association for Retarded Children*

ONE of the most heart-warming aspects of being the mother of a retarded child these days is in being a part of a profound partnership which is developing between lay and professional people.

Of all life's problems, those presented by a handicapped child (and particularly a mentally handicapped child) require the utmost in teamwork within professions, among professions, and between professional and lay people, especially parents.

All over the country we parents are attempting to assume responsibilities appropriate to the partnership through helping to define our separate roles and in heightening our communications in order to save other families from unnecessary trauma.

Dr. Martha M. Eliot, Chief of the Children's Bureau recently said:

"When officials of public agencies ask what kinds of services should be provided for retarded children, my advice is 'ask the parents' . . . [they] are often best qualified to say *what* help they need, though professional persons will have to provide the *hows*."<sup>1</sup>

Thus, we laymen and professionals are indispensable to one another in our efforts to make up for past neglect of this serious medical, emotional, social, and educational problem.

Perhaps I can bring together for the readers of this journal for professionals some of the written and spoken insights which have come my way from both professional workers and parents. These, I feel, are relevant for those of you who find it your task to help families face this heartbreaking problem—whether you are physicians, psychologists, social workers, nurses, teachers, or administrators. On the basis of these and my own experience I urge:

### *1. Tell us the nature of our problem as soon as possible.*

When I said this to a class of students of child psychiatry at the University of Minnesota Medical School, I was asked by an alert student, "But Mrs. Patterson, what can the physician do when he is not sure himself and doesn't want to worry the parents?"

"Just be honest with us," was my reply.

It takes great sensitivity and intuition to take a mother's couched remarks and detect that they spell "worry." Often we parents are concerned just as early as our practitioner, but we are reluctant to put our fears and worries into words. However, we give plenty of hints that we want our professional counselor to help us get them into words, to lead us on the proper course—whether that means waiting a while or consulting with specialists immediately. It is a wise counselor who knows when he does not have the answers and is willing to admit it.

One of my psychiatrist friends put it this way:

"When I am faced with a worried mother or father *I have got a problem*. Either there is something wrong with the child, or something wrong with the parents, or both. And if I can't identify the trouble, then I am obligated to get this family to someone who can."

### *2. Always see both parents.*

Fathers are parents, too, and all professional workers need to be reminded of this. Both parents should be present whenever possible, and at least on first consultations regarding a child's handicap.

It is very difficult for a mother to go home and restate, interpret, and answer questions about a prob-





Learning the truth is an agonizing experience for a parent of a badly handicapped child, and suspicion of mental retardation may be fought off desperately. When a father does not receive a professional explanation directly, he may refuse to accept the reality the child's mother can no longer avoid.

lem she does not clearly understand herself. Often the problem, with its fears, has brought about a lack of communication between mother and father. This is particularly true in a young marriage or when the retarded child is the first child. Establishing adequate communication is difficult in any marriage. Finding the words to support one another in *this* problem has been impossible for some of us. We have needed an objective person through whom to talk.

Unfortunately, all husbands (and wives) are not like the one who, when he learned that their little daughter would not progress like other children, said to his wife: "Honey, we don't know what lies ahead of us—but whatever it is, we can handle it because we are strong people."

Many of us can find this strength, however, if you will help us.

Another reason for seeing both parents is that both need to be pulled along together in their understanding and acceptance. I have seen too many mothers who realized the need for institutional care and were ready to "place" a child while the fathers trailed behind ignoring reality, not to recognize the great need for a common understanding. Sometimes it is the mother who will not admit that something is wrong and insists that her child stay in regular school classes when a special course of study is indicated,

while the father suffers along in silence, afraid to precipitate the issue. If you but knew the isolation that can exist behind our four walls!

### 3. *Watch your language.*

Parents need to understand the implications of their problem, but too often we are given professional gobbledegook, or at the other extreme, plain talk of an obnoxious variety. Words like "idiot," "moron," and "feeble-minded" used to be excellent and descriptive clinical terms but they no longer apply to our retarded children. Unimaginative writers and purveyors of so-called humor have polluted the meanings with connotations of social or moral deficiency in the mentally normal.

On the other hand, there was the doctor at a residential institution who wrote to two parents stating that their son was ill with "cervical lymphatic adenitis." The worried family did considerable research to find that the child simply had swollen glands of the neck.

The child psychiatrist, into whose capable hands my husband and I finally could put our problem, was very sensitive in his use of words. He avoided "moron," "feeble-minded" and even "mental retardation" by encouraging us to evaluate our child's developmental status. And when he confirmed our findings, we felt quite pleased with ourselves. He always referred to our boy as "your son," "your lad," or "Stephen" with a voice filled with great compassion so that we started thinking more about Steve's problem and less about our own hurt egos.

### 4. *Help us to see that this is OUR problem.*

One way, of course, is by example—by not taking the problem over for us.

Too many well-meaning professional people in the past have thought they knew what was good for us and have recommended, even insisted on, institutionalization. We know, now, that denial of the existence of the child is not the solution for either child or parent, that abandonment is not the answer, and that it is psychiatrically unhealthy to rob parents of their responsibility for planning. Only as we parents are helped to work through our problems can we find any peace of mind. If we have not planned for our child ourselves, if someone else has made the decisions, we have not really made up our own minds and so must keep going over the ground again and again. We may never be at peace with the solution which was reached for us.



Administrators of institutions tell us that the best help for families in adjusting to their child's placement is the fact that the parents themselves have decided—with adequate professional guidance, of course—that placement is best for the child in relation to the total family welfare.

There is another reason for showing us that this is our problem. You have no idea how much unprofessional, unsolicited, and untried advice we get from well-meaning people—our neighbors, relatives, friends and even strangers standing on street corners. When, with your guidance and example, we realize that *this is our problem*, we can shut our ears to the static and rely on our own judgment. But we need your professional support in helping us to feel competent in making these decisions, your confidence that we will ultimately make the proper decision for care in our particular case, your assurance that there is no failure if we change our plan when circumstances change—life situations and retarded children present different problems at different times. You can help us explore the possibilities for meeting our problem; support us in adjusting to our decision; act as a continuing sounding board against which we can bounce our own thinking; and give us a good, sturdy shoulder on which to lean when we get dizzy going through the maze of decisions.

#### 5. *Help us to understand our problem.*

Parents differ in the quantity and quality of information they can absorb during different phases of this problem. What they want and need depends greatly on the individual, but many of us have had to search for the knowledge we needed in order to understand our child.

Six years ago, when I began my search, a severe scarcity existed in printed material on the subject of mental retardation. Today, there are many fine and helpful publications in this field. One of the best that I have seen for new parents is Jacob's "New Hope for the Retarded Child,"<sup>2</sup> which is inexpensive enough to be used as a handout. Many other books, bibliographies, journals, and pamphlets provide excellent sources for parents.

Regardless of what we parents are able to read and absorb, we will always have questions to ask. We will continue to need support from someone, whether our child is at home or away—particularly in those days which follow the confirmation that mental retardation *is* our problem.

One medical counselor asks parents to come back

several weeks after he has given them the bad news, knowing that they will have questions which could not come to the surface during the emotional strain of hearing the verdict. Moreover, he sees to it that the parents get to a social worker and he also urges them to join an association for retarded children.

Frequently he turns their names over to the local association's "parents counsel committee" requesting that some mature couple—a mother *and* a father—call on them. He has found that parents who have successfully faced their problems can offer a special kind of help to new families which transcends his professional services. Further, he has seen the therapeutic effects of parents working together in organizations to improve the lot of the retarded and their families. Incidentally, he was initially one of the "pros" who were afraid of this "lay" movement.

#### 6. *Know your resources.*

In referring to services, Dr. Eliot has called the retarded child "nobody's baby." Certainly there is evidence in most States that services are disjointed and uncoordinated. Rarely is there any one place which can put parents in touch with the resources that *are* available.

In Minnesota, where the county social worker is the local resource for parents, a booklet, "You Are Not Alone," telling parents where and how to seek help, has been distributed to members of the State medical association, county welfare boards, clergymen of all faiths, family and welfare services, clinics, public-health nurses, associations for retarded children, and newspaper editors in the hopes that the booklet (or the information) will be passed along to parents. It was produced by the statewide Conference Committee on Mental Deficiency, a professional-lay body.

California has started meeting this problem with information centers for the parents of retarded children, set up in Los Angeles and San Francisco by the State department of mental hygiene. The psychiatric social workers assigned to this task have a variety of functions—counseling individual parents, putting them in touch with resources, providing information to public and private agencies, and serving as consultants in community planning.

Other States are developing a network of clinics with built-in social services for the sustaining help which is so necessary.

Anyone who has carried a handicapped child from one waiting room to the next in an effort to gather

resources into one piece, will appreciate the significance of these several efforts to avail parents of the services that do exist.

#### 7. *Never put us on the defensive.*

All parents make mistakes in raising children. Those of us who have a retarded child are bound to make errors, but we should not be made to feel guilty about them.

One day I said to my medical counselor: "You know, of course, that I was angry at you for a good long time for 'confirming my diagnosis,' but never once have you put me on the defensive about it or any of the mistakes that we have made in relation to Steve."

"Why should I?" he countered. "How do I know I could have done any better than you, had I been in your circumstances?"

He went on to give this definition of "good parents":

"Parents are good parents, when to the best of their ability, understanding, and circumstances, they meet as adequately as possible the needs of their children."

#### 8. *Remember that parents of retarded children are just people.*

This has been *my* most amazing discovery. We are just people with a serious problem, a great sorrow—a living sorrow. We have the same strengths and weaknesses as others in the general population. We have the same problems, the same handicaps. But when the burden of mental retardation is heaped upon us, often these problems and defects are magnified and we, in turn, create problems for those of you who must deal with us. But *as a group*, I do not think we should be considered abnormal, particularly in view of the poor cultural attitude towards our problem, the lack of interest and services, and the fact that some parents have made great personal and family sacrifices to carry this "cause" to the public conscience.

You cannot generalize about parents of retarded children any more than you can generalize about retarded children. Gifted, average, or limited, any of us can find our problems complicated by our own emotional makeup. Professional people working with us must learn to appraise these variables in our intelligence and emotional stability.

Apropos of this are the technical articles which

some of us read. Why do we *always* face such words as "anxieties, hostilities, frustrations, guilt-feelings," and other emotionally charged words to describe our reactions? Such pseudoscientific certainties merely serve to make parents feel even more inadequate, it seems to me.

You should take seriously the comment of a New Jersey parent: ". . . Is not what appears to be 'guilt feelings' to professionals, merely concern with the child's welfare, mingled with grief over his handicap?"<sup>3</sup>

"All parents experience some feelings of guilt about illness in their children . . .," Dr. Julius B. Richmond, pediatrician, of Syracuse University has said. If outward manifestations of these feelings persist in us after you have assured us that "no act of omission or commission" on our part has been responsible for the condition of our child, perhaps our feelings might be more aptly described as "regret." We are bound to feel regret if we have rejected this child, if we have struck out at him and created problems for him. With this regret we very likely feel anger at not having had the proper guidance at the times we needed it.

Might not some of our hostility be nothing more than righteous indignation over the neglect of our problem? Actually, if some of the pioneers in the parent group movement had not become "mad" in the early days, our problem would still be largely ignored. Who can say, on the basis of present knowledge, when anxieties are neurotic overreactions, if parents must ask: "What will happen to this child after we are gone?" "How can we pay for expensive care outside our home?" "Where can we hire a sitter so that we can take a vacation?"

Whatever labels we use for these feelings, they have added up to a great determination—you might call it "compulsion"—for some of us to see to it that new parents coming along can walk a smoother path. And there is considerable evidence that many of these new parents are avoiding some of the emotional scars which some of us bear.

Dan Boyd, a New Jersey parent, has described three stages in the growth of a parent of a mentally retarded child: (1) Why did this happen to me? (Self pity.) (2) What can I do for my own child and family? (3) What can we do for others?<sup>4</sup>

These stages can be intermingled. The fact that a parent is working in an organization "to help all retarded children" does not necessarily mean that he has grown with his own problem. Some can be stage-3 leaders, without having graduated from

stage 1. Such self-pitying parents are the hardest to help. It often takes a long wait and the greatest skill on the part of professional counselors and their parent counterparts to help them to begin to make realistic plans for their own child.

Most parents, however, mature quite rapidly under the stimulus of the group. Self-pity fades when they find that they are not alone. Soon they are seeking to learn from and emulate the parents who have met their problems successfully. And before they know it, they are experiencing the healing that goes with helping another family. Some move on to be eager for all parents to have access to the organization which has rescued them from desolation.

Even these mature stage-3 parents can slip back, temporarily, into stage 2, when a problem arises at home or when previous decisions must be reviewed. During these times we can be very difficult. Then you must support us, while feeling "nothing but plain, simple, humble reverence before the mystery of our misfortune," to use the words of John Cowper Powys.<sup>5</sup>

This means that you must look at your own feelings about us and our children. If you do not have a natural feeling of concern for the mentally retarded, if you feel indifferent to or repelled by children who are not mentally normal or by parents under great stress, then you should not be dealing with us at all.

*9. Remember that we are parents and that you are professionals.*

Some of us are becoming so well-informed in certain areas of this problem and we are associating with you in so many different pursuits that, at times, it must be difficult to remember that we *are* parents and, as such, will always be emotionally involved with our own problem and our own child, regardless of the "objectivity" we may have about the problem generally, or another family's problem, specifically. In communicating with us you must be clear as to whether you are speaking as counselor to client, adviser to organization member, coworker, or personal friend. In this we expect you to use professional judgment.

For example, don't in front of us: belittle or countermand the opinion of one of your professional partners; make critical remarks about other parents and their handling of their child; jump to conclusions about our case without adequate clinical study

or knowledge of the facts. And, of course, don't try to do a job that is outside your professional discipline.

When we see so much that needs to be done, we have little time for professional jealousies, or for the individual who uses mental retardation as a ladder to personal success. It does not take long for us to pigeonhole a "problem professional" whose own emotional difficulties are getting in the way of our efforts.

*10. Remember the importance of your attitude towards us.*

Sometimes I think your colleagues place too much emphasis on "objectivity" and not enough on "loving kindness." Certainly we expect you to be objective about our problem. But about us? Never! A really gifted professional person cannot *help* feeling—being subjective, attempting to stand in our shoes and to look out at our problem through our eyes—in the process of helping us. Psychiatrists call this "empathy." It is only through empathy that you can divine the proper words and acts to help us.

There are greater depths and breadths in helping parents of retarded children than many of you have realized in your initial attempts. It has been as exciting for some of us parents to watch professionals grow as it has been rewarding for professionals to watch some of us parents grow. We can help each other become more effective people through our partnership.

You are obligated, it seems to me, to "feelingly persuade" us as Shakespeare said, to help us find "what we are." We have many strengths. If you can help us convert our problem into good for mankind, help us find the sweetness in the uses of our adversity, *you* will find a far more precious jewel in your professionalism than you ever thought existed.

And you will be professionals in the most noble and magnificent sense of the word.

<sup>1</sup> Eliot, Martha M.: Unpublished address to the National Association for Retarded Children, Boston, 1954.

<sup>2</sup> Jacob, Walter: New hope for the retarded child. Public Affairs Pamphlet No. 210. Public Affairs Committee, New York. 1954.

<sup>3</sup> National Association for Retarded Children, New York. CHILDREN LIMITED, 4: 5, June 1955.

<sup>4</sup> Boyd, Dan: The three stages (in the growth of a parent of a mentally retarded child). Pamphlet. National Association for Retarded Children, New York, August 1953.

<sup>5</sup> Powys, John Cowper: The meaning of culture. New York: W. W. Norton & Co. 1929.



## GROUP DISCUSSION IN A CHILD-HEALTH CONFERENCE

RUTH CUMINGS, M. A., and the staff of the Mamaroneck Health Center\*

THE NEED for wider use of group discussion techniques in teaching about health is supported by educational theory which suggests that there can be little education without participation. Therefore, parent discussion groups under the leadership of the public-health nurse are increasingly finding a place in child-health conferences. They emerge from the theory that the basis for information and teaching lies in the shared experiences of the mothers. In fact, workers in public health and health educators across the country are emphasizing the need for more personal and informal contact through group discussion to improve public-health programs.

This paper is a report on the experience of several nurses engaged in a group discussion project in a health agency with a program coordinating the facilities and services of the village, town, and county departments of health. The staff introduced mothers' discussion groups in conjunction with the child-health conference.

For several months prior to starting the group discussions, the staff worked with the mental-health consultant in order to achieve improved interviewing techniques in individual conferences and in field visits. Then the focus of inservice education efforts was broadened to include not only more knowledge and understanding of child development and mother-child relationships but also of group discussion techniques and of their own roles and responsibilities as leaders and group members. The nurses read materials that would help them expand their knowledge of child-health needs, growth patterns, and the emotional concomitants of growth and development.

\*Winifred Taylor, Rose DelDuco, Margueretta Covert, Marion Sweatland, Judith Lander, Mary Pinto.

This inservice education program had two purposes: to broaden and strengthen the nurses' knowledge and to help them develop facility in using this knowledge with confidence and skill in the group situation.

Several factors were taken into consideration in organizing the mothers' groups in order to enhance their significance as a learning experience. These included: the organization of the groups; the orientation of the mothers; the care of the children during the discussion; and the provision for continuity between the group discussion and the clinician's service.

### *The Beginnings*

An experimental group of 15 mothers having children of the same age was formed within one child-health conference. The nurses made home visits to let the mothers know about the proposed change from individual conferences to a half-hour group discussion to take place before the children were seen by the clinician. They explained that the change arose from the staff's desire to make the waiting period more profitable for both mother and nurse and to improve the child-health service.

After three sessions, the interest and enthusiasm of the mothers and nurses prompted the incorporation of group discussions into each of the weekly child-health conferences. At present all of the agency's child-health conferences provide for mothers' discussion groups as well as for physical examinations of the child and for individual medical recommendations regarding them.

Some changes were made as a result of the initial experience in an effort to provide an optimum educational experience for the mothers. One involved the care of the children during the discussion period.

The mothers at first met with the public-health nurse in the large waiting room. Half of this room



had been set up as a play area for the children, to be supervised by another nurse, thus freeing the mothers but leaving them accessible if need arose for their attention. However, as it turned out there were few separation problems, and the mothers obviously needed a quieter spot for their discussions. Therefore, the discussion group was moved to a smaller room and the entire waiting room left for the children to play in. The chairman of the agency's lay board organized a group of volunteers from the board members and the local Junior League, called play supervisors. The nursing staff outlined the program's objectives for the volunteers and oriented them to their new functions and responsibilities. The board purchased playpens with pads for the toddlers and babies. Books and toys were accumulated for children of various ages.

At present a public-health nurse with good understanding of child development carries the overall responsibility of the play area and the supervision of the volunteers. This arrangement not only serves the children but offers the nurse a supervisory experience and an opportunity to observe the range of growth and behavior in infants and preschool children.

Experience showed that a half-hour discussion period did not provide the mothers with sufficient time to discuss adequately their ideas and practices. Therefore, a one-hour period was initiated. This has proved to be more satisfactory. After the period is over the clinician sees the mother and child. In some instances the mother may have a postconference interview, usually with the play-area nurse.

The groups are still formed of mothers having children of the same age level. When the mothers and children arrive at the health center they are greeted by a volunteer and given identification

tags for the children and their belongings. These help the play supervisor to address each child by his name and to know whether and when a bottle needs to be given. After the mother has prepared the child for her absence, the child remains in the playroom with the play supervisors. However, if separation is a problem the child is allowed to go with the mother.

### *Content of Discussions*

The introduction of the mothers to group conferring is simple and to the point. The nurse explains to each new group that individual conferences have not always seemed productive and have not seemed to meet the mothers' needs; that since the mothers are the persons having experience in rearing children they can help each other by sharing knowledge of what they are doing and exploring new ways of helping their children grow. Then the mothers introduce themselves to one another. Generally they agree that they would like to tell each other about what they are doing. While most of them are not reluctant to talk about their children, some find it hard in the beginning to express themselves, but through the nurse's skill in group leadership are helped to make their comments and contributions. A few are not vocal but indicate their awareness and approval by smiles and nods, and subsequent comment.

Sessions of the established groups begin with mutual greetings among the members and a brief review of previous sessions. In most of the groups the mothers start immediately bringing up their concerns. These include some common areas of interest—eating habits, sleeping habits, toilet training, thumbsucking, pacifiers, addition of new foods, aggressiveness, shyness, discipline, appetites for bizarre foods, bed wetting, spoiling, appropriate

In group discussions, conducted by a public-health nurse, these mothers talk about their common problems and thus learn to understand their children better and help them grow. The meetings are held as part of the weekly child-health conference.



toys, the meaning of play, sibling rivalry, and the father's role.

The leader seldom finds it necessary to initiate discussion. A typical session might start with some of the mothers expressing concern over changing eating patterns in their 2-year-olds—"eating less than he used to," "refuses eggs that she used to like," "gets more on her than in her mouth." The ensuing discussion would center around the lessened food needs at this age, the seeming need to experiment with foods, the importance of weekly or monthly intake, and the permissive or punitive attitudes expressed by the mother around the giving and receiving of food.

Then a mother might voice her concern for her 2-year-old who "will not share any of his toys" and the discussion proceeds: "They are really quite selfish." "With three children one can't afford three of each toy." "What about two girls who are the same age?" "Maybe this is the way they all act, if each child seems to do it." The nurse would lead the discussion into the difficulty in sharing toys, in playing together, and the kinds of imitative play engaged in by 2-year-olds. The session might end with a heated discussion of aggressive play and of children's practice of hitting and biting at this age—very difficult for most mothers to understand and handle in a constructive way. In summarizing the discussion the nurse would offer an opportunity for its continuation at the next group session.

After such a session the mothers frequently make remarks showing what the experience has meant to them: "I feel so much better to know I'm not the only one with problems." "I guess all children are different and can't be treated the same even in the same family." "I can see that my child's feelings are important even at this age." "I guess there is no right way or wrong way; it's an individual thing." "Before, I thought the nurse was only interested in my child; this makes me feel included."

When the discussion period is over the mothers prepare their children for weighing and measuring and for examination by the clinician. By assisting the clinician, the nurse group-leader provides a continuity of service and is able to coordinate what the clinician reports or advises with the concerns the mother may have expressed in the group. The public-health nurse in charge of the play area assumes the responsibility for postconferences, giving the mothers any information needed regarding referrals elsewhere and answering any further questions they might have.

At the completion of the child-health conference, the staff nurses, supervising public-health nurse, mental-health consultant, pediatrician, and visitors meet together to discuss the morning's events. The visitors are usually university students taking their field work with the agency, school nurses, and other nurses from the county staff observing with the idea of instituting group discussions in their own child-health conferences. The purpose is to share knowledge so that each staff member might better meet the needs of the mothers.

The participants in these staff conferences bring in the findings of pertinent reading and study, define mental-health concepts, review their clients' home situations and explore the possibilities of helping with some of the problems of parent-child relationships through home visiting, which is where their interviewing skills are brought into full play. They also discuss their group methods and leadership techniques in an effort to understand the dynamics and improve their skills, the effective use of audio-visual aids, and any additional reference material that might add to their knowledge of both group-work and child health. Through such staff conferences, evaluation and inservice education are continuous.

### *Some Results*

Since this program has been in operation, the nurses have noticed that some changes in relationships have taken place. The mothers are more relaxed and less formal in their approach to the nurse, to each other, and to the clinician. Concerns about their children's behavior which in individual conferences they would not have considered relevant or would have been reluctant to bring up have emerged rather quickly in the group. The permissive atmosphere, the commonality of their concerns and their feeling of status as mothers, and a shift in nurse-mother relationship from authority-client to one of more equality and closeness in purpose have developed.

Formerly there was less socializing in the waiting room than now. The common attitude among the mothers was watchfulness in terms of their child's behavior and its effect on the opinion of others. Talking together about their concerns and practices in raising their children seems to have resulted in the mothers' greater acceptance of each other as people and in being more aware of others and their problems. The pediatrician has also observed that the

mothers' behavior in conference with him generally seems to reflect increased self-esteem.

After 6 months of holding mothers' group discussions the staff decided that some concrete material should be obtained to help determine whether or not the needs of the mothers were being met and how the nurse leaders could best proceed. Therefore, a questionnaire was formulated consisting of 15 questions relating to the group discussions. A school nurse temporarily employed during the summer interviewed 21 mothers in their own homes of the total of 79 mothers who had participated in the groups. She was selected on the theory that the mothers might be more frank in answering her questions since they did not know her. Each of the 21 mothers was chosen for interview because she had attended at least four sessions.

### *Mothers' Opinions*

In answer to a question about what they liked about meeting with other mothers, 19 mothers expressed positive feelings and 2 stated that they had no problems to bring to the group. Of these two, one said "Nobody takes my advice." This was the mother who was most negative about the experience. The most frequently cited reasons for positive feelings were: sharing knowledge and discussing common problems; relaxation away from the children; and a better nurse-mother relationship.

Four reasons for disliking the groups were cited in answer to another query. They were: separation from children; monopolizing of the discussion by a few; no provision of a ready answer to a problem; and a preference for individual conferences.

Asked about concerns they would like to talk about, the mothers mentioned: helping children get along with others; feeding; toilet training; discipline; thumbsucking; speech development; and sex education. To a question about whether they had felt free to speak to other mothers about these concerns, 15 mothers answered "yes" stating that in doing so they received new ideas and suggestions, learned about growth and behavior, and obtained greater understanding about the role of the father in family living. Of the 4 who answered "no," 2 said there had not been enough opportunity to talk, one said she needed no help, and one said the group gave no definite answers to her problems. Two mothers left the question unanswered. Another question about freedom to talk brought two negative responses, one attributed to shyness and the other

revealing a feeling of rejection because "nobody takes my advice."

Since most of the children were in the playroom during the discussion period, the mothers were asked about their feeling in regard to separation. Eleven mothers had expected from the beginning to leave their child for this period and 4 others had expected to after the first session. The mothers who had expected separation reported that they felt no concern about this, but 2 of the 6 who did not expect it worried about their children's crying.

To a question dealing with the bearing of the time of meeting (sometime between 9 and 11 a. m.) upon attendance, 15 mothers replied that the time was irrelevant, and 6 said it was too early in the morning. When asked if they wanted to get together more often than in their meetings at the child-health conference, 13 replied "no" and 8 replied "yes," but apparently the question was not clear, because they preferred 1 to 2 months as an interval which was the frequency most of them were meeting.

To the question, "Has the group helped you to understand your child?" 19 answered "yes" and 2 answered "no." One of the negative respondents said: "I helped the group." Six said understanding came about through learning from others; 7, through an increased general understanding of growth and behavior; 2, through the opportunity of comparing behavior; 1, through finding an easier way of doing things; and 1, through the films which had been shown to the group. Four gave no definite answer.

Nineteen of the mothers expressed the opinion that group discussion was a good way of learning; one preferred an individual conference; and one did not answer. When asked if they had learned about things they did not previously know, 18 answered "yes," 2 answered "no," and 1 said only that it was difficult to obtain answers to problems from the group.

Another question was: "Do you feel better knowing that other mothers are having the same experience you are?" This led to 19 "yeses" with remarks such as "all in the same boat," "more relaxed," "less worried about what I'm doing." Two "noes" carried no explanation.

Twenty mothers said they felt free to talk to the doctor but 19 of them reported that this was not a new feeling for them. One mother did not answer this question.

The final question asked for suggestions for improving the child-health program. Nineteen mothers had no suggestions. One expressed a preference



for individual conferences; another asked for more movies and also suggested that the group complete discussion of one subject before starting a new one.

The results of the questionnaire seem to verify the nurses' impression that the mothers were having a favorable reaction to their group experience—for many, their only group experience. However these results also showed that even in such a small sampling of mothers, there are some who are not comfortable in the group situation, and that therefore group discussions cannot completely take the place of individual conferences.

The discussion groups have continued with some changes which have grown out of experience and the results of the questionnaire. However, the clinic still carries on individual conferences. Many mothers avail themselves of both types of educational opportunity. The groups vary in size from 6 to 12 members. New groups of mothers are formed among those registering with new babies. Occasionally new groups of mothers with older children are also started, but usually newly registered mothers with older children join an existing group.

The mothers' attendance at group meetings and the continuity of their learning experience are based on their attendance at the child-health conference. A nucleus of mothers from each group keep coming regularly over a period of from 4 to 5 years. These mothers get to know one another quite well as their children progress from infancy through the preschool years. The groups meet at intervals of 1 to 3 months, depending on the health supervision needs of the children.

### *Conclusions*

This experience in group education among mothers within a child-health conference setting seems to lead to the following conclusions:

1. Group discussion offers mothers an opportunity for expressing the commonality of parental experience and for sharing their problems, concerns, thoughts, and practices.
2. Active participation helps the mothers to release their feelings and to gain confidence in themselves through mutual support and reassurance.
3. Through their own contributions, the mothers realize the unique individuality of each mother and child and are stimulated to request and accept more knowledge of child growth and development and of the meaning of parent-child relationships.
4. Some questions might be raised regarding the continuity of learning in this project, especially

in comparison with groups that meet more frequently. Many community parent-education groups offer a more intensive learning opportunity, but the majority of parents in these groups are not those who use public-health facilities to any great degree. A large segment of the population of many communities are not reached by community educative groups either because of their low economic or social status or their lack of previous experience. Through mothers' discussion groups the child-health conference can offer a dynamic experience within the existing framework of preventive public-health services to a part, at least, of those who are otherwise unreached.

Our experience so far has shown that these mothers are not interested in a more intensive learning experience but prefer to meet within the familiar child-health conference, feeling that it takes time for their children to grow and that since changes occur slowly frequent meetings are not necessary. Possibly this slower process of education carried on over a longer period of time is of real value in meeting the needs of these women.

5. Provision for the care of the children during the sessions allows the mothers to relax and so to participate more actively in the discussion. It also gives the nurses an excellent opportunity to observe child behavior in separation from the mother and in play with other children. Most nurses have had little opportunity to observe well children. This experience can be transferred into a nurse's teaching in all child-health supervision.

An interesting byproduct of the project can be found in the eagerness with which some children approach the health center. The additional help provided by the volunteers has proved most effective in terms of service and community interpretation.

6. The nurses have found this program to be a stimulating and satisfying learning process. The dynamic interaction within the group results in a real expression of the mother's needs, making it possible for the nurse to share her knowledge in terms of those needs. The nurse's presence as a leader helps the mothers feel secure in meeting each other and sharing their mutual interests.

With the universal concern for mental health and improving interpersonal relationships, nurses are increasingly being asked to make concerted efforts toward carrying these responsibilities in community nursing programs. Such efforts require new learnings and new methods in health teaching. Group discussion is an effective way of teaching mothers about important aspects of child health and growth.

*Unmarried mothers and social workers  
express their thoughts on . . .*

## THE MEANING OF THE MATERNITY HOME

JANE E. WRIEDEN, M. S.

*Superintendent, Booth Memorial Hospital, Cleveland*

**W**HAT MEANING does the maternity-home experience have for the unmarried mother?

In an effort to find the answer I recently sent this question to 277 maternity homes and other agencies. Ninety-six agencies in 39 States, Hawaii, District of Columbia, Alaska, and Canada responded—51 maternity homes, 27 family and children's agencies, and 18 State welfare departments. Workers in agencies referring unmarried mothers to maternity homes, workers in the maternity homes, and workers in other agencies talked in staff meetings and interagency conferences about the meaning of a maternity-home experience. Unmarried mothers themselves talked in group sessions and in interviews with caseworkers. Altogether about 100 social workers and 200 unmarried mothers participated informally in the preparation of this paper.

Social workers in 9 of the maternity homes talked with approximately 80 unmarried mothers about the question. Three of these social workers used a simple questionnaire to supplement interviews or group discussion. They contained such questions as: What do you think the maternity-home experience can mean to an unmarried mother? What are you looking for in a maternity home? What can we do so that the experience can have more meaning? Why did you apply for care in a maternity home? What did you think the home would be like? How is the home different from what you expected? What is

your opinion about living with a group of girls sharing the same experience? The reply from one maternity home came to me directly from an unmarried mother.

Also included in these findings is material from my own routine interviews with 125 unmarried mothers during several months. I make it a practice in interviews with an applicant or a resident of our home to encourage her to talk about what she is looking for in our service. At the time of discharge I try to get the mother to talk about the experience she has had with us by suggesting that she tell me how she feels about it, what helped her most, what was difficult, and what suggestions she might have for improving the service. During the period of working on the paper, I also had an opportunity to talk with a few unmarried mothers who returned to see me from 6 weeks to a year after living in the home.

The material from the social workers makes clear some have not given enough serious thought to the real meaning of a maternity-home experience. Others are thinking a great deal about what a maternity-home experience does, and can, mean to the unmarried mother, to the caseworker, and to others. All of us need to do much more thinking and much more research, using information coming from the unmarried mother herself, before, during, and after a maternity-home experience, if we are to understand the meaning of such an experience.

Any consideration of this meaning must be colored by the answers to two questions: What maternity

---

Adapted from a paper presented at the 1955 forum of the National Conference of Social Work, San Francisco, Calif.

homes are we talking about? And how do we regard the unmarried mother?

By maternity home, I mean a good maternity home—one having a sound philosophy and clearly stated flexible policies; adequate casework and groupwork with psychiatric and psychological consultation; adequate plant, facilities, and location; provision for adequate medical care; effective public relations and sound financing.

By unmarried mother, I mean a person with all the dignity of human personality who comes to our attention because she is pregnant out of wedlock. I do not mean a category, or a statistic, or a social or psychological phenomenon, or a resource for adoptable babies. I mean a *person*.

I emphasize this because too often we lose sight of the person and her individuality in our preoccupation with the "unmarried mother." She is a person whose psychology must be understood in terms of her early childhood relationships carried over to the present, especially the mother-daughter relationship. Her pregnancy is often a purposive acting out of her inner drives.<sup>1</sup> While some professional workers regard the unmarried mother's pregnancy as a symptom of emotional disorder or disease, Dr. Ner Littner suggests that the pregnancy actually is an evidence of attempted emotional recovery; that is, the best solution the person can find to her emotional dilemma.<sup>2</sup> Whether symptom of emotional disorder, or symptom of emotional recovery, the *person* not the pregnancy is the treatment focus.

What then does, or what can, a good maternity-home experience mean to such a person? What significance do the casework and groupwork services and medical and nursing care have for her in this setting? In studying the data to which I have referred, I find that the meanings center chiefly around three areas:

1. Meanings inherent in "acceptance."
2. Meanings inherent in "shelter," "security," and "protection."
3. Meanings inherent in "group living."

### *A Place of Acceptance*

The material shows that frequently, if not always, all the person pregnant out of wedlock is really consciously looking for is a "place"; a place to get away to, a place to stay in while having a baby because she, and what she has done, are not acceptable in our culture. Tied in with this is her need for se-

crecy. Sometimes it is not the unmarried mother herself, but rather a parent, or worker, or some other person, who wants her to find a place away from home. Frequently she is seeking a place to go because she is without resources.

The maternity home means such a place, a particular spot. Such practical meanings as a roof over one's head, three good meals a day, a comfortable bed to sleep in, medical care, a doctor, a nurse—are all wrapped up in this "place" to get away to and to stay in.

The person seeking this shelter soon finds that the maternity home—if she is in a good one—is also a place where she is accepted, taken as she is. In fact, she sometimes senses this with the very first touch of the maternity home—the telephone call, the letter, the interview. She knows this not so much by what the maternity-home worker says, as by what the worker *is*—which reveals itself in attitudes and actions. One unmarried mother summed it up in four simple words: "You give me strength."

The importance of such acceptance emerges distinctly from the material. Said one applicant to the maternity home: "I want a place to stay and someone I can depend on." Another unmarried mother, telling of a friend's negative maternity-home experience, said: "The work was hard; the food was poor; you felt you were looked down on; you felt condemned." She added, "Here you feel you're wanted and that you're someone special." The social worker who knew the meaning of being accepted and accepting, said simply and gently, "You are."

Being accepted as a valued person is rarely what the unmarried mother expects. She really expects disapproval and criticism. To the degree that she is truly accepted by the caseworker and other staff members, the maternity home will have positive meaning for her. A month after leaving the maternity home an unmarried mother said, "What I miss most is the attention."

Acceptance rests on the principle of the right of every individual to self-determination and on the belief in the infinite value of human personality. Acceptance means more than taking a person as she is; it means being concerned and caring. Acceptance involves relatedness to a warm person. This relationship is the heart of a maternity-home experience. If a maternity home had no other meaning than a "place" to help the person to experience such a feeling of being accepted, of being wanted, and of belonging, it would be worth a community's investment. But it can, and does, mean more than a place



when the acceptance is related to the individual's needs and to total treatment.

### *A Place of Security*

Equally as important as a place of acceptance is the maternity home as a place of security. This is also plainly revealed in the material. Recurring throughout are the words "shelter," "protection," and "security." A close examination indicates that the meaning of all three words is basically the same: freedom from exposure to danger; feeling of, or assurance of, safety or certainty; freedom from anxiety and doubt. It includes not only physical but emotional protection, freedom not only from external but internal pressures. It also includes the need for privacy and confidentiality. These are positive feelings, not to be confused with stifling shelter, patronizing protection, and pseudo-security.

By security I do not mean a wall around an enclosure to separate a person from the world of reality, but rather a bridge between two points—the reality of the present and the reality of the future. This sense of real security for the unmarried mother grows out of acceptance of her as a person in her own right with all the dignity of human personality. It is not a new experience only for girls who come from openly rejecting homes and families. It also has meaning for those who seem to have the support of their families, since somewhere there has been missing in their earlier relationships this sense of being accepted and of belonging.

The material also includes numerous references to the security which comes to the unmarried mother from having good medical care readily accessible.

Acceptance and security take on added meaning in terms of group living. The group in the maternity home, of course, is constantly changing. Moreover, groups, like individuals, vary. Furthermore, there are groups within the larger group. The group may be diversified as to age, education, religion, occupation, and economic and social background. Paradoxically, what the members of the group have in common, in addition to pregnancy, are those traits which create individual differences—human attitudes and feelings.

### *Group Living*

In the material, group living and related factors are mentioned by social workers and unmarried mothers even more frequently than acceptance and security. Some respondents merely mention group living as a positive meaning of a maternity-home

experience without analyzing its effect. Others attempt to identify and to define some of the meanings inherent in the experience. These, they find, derive from the fact that while living in a protected community such as a maternity home a person can drop the pretense under which she has been living and face the fact that she is pregnant. Companionship and opportunity to discuss problems with others in the same situation result in less need to deny the pregnancy. Identification with others in the same situation lessens emotional isolation and helps to regain emotional balance.

One group of unmarried mothers was asked directly: "What is your opinion about living with a group of girls sharing the same experience?" Their comments are revealing: "You feel less lonely—less self-conscious—less guilty." . . . "You don't worry as much when you know others have the same trouble." . . . "Everyone is equal." . . . "You realize a lot of things, and you look at the situation in a different light." . . . "I was ashamed when I came. I drew strength from others who seemed to bear up. I was relieved." . . . One girl who had never been away from home before thought it was "fun living with the group"; "it gave me more confidence in myself." Another said it was interesting to hear about the other girls' situations, but she "got tired" of the "same old chatter" about diet, weight, and the like.

The material reveals that reality in group living helps the unmarried mother to face her own reality situation. Learning to understand others and to be comfortable with others, especially those who are different from herself, helps in self-discovery and self-understanding. Learning to accept others as she wants to be accepted is a step in "growing up." Learning to use permissiveness within necessary limitations, where limits make sense and are administered by those who care and are fair, contributes to the development of healthy personality. The chance to live in a warm, happy atmosphere in cheerful and attractive surroundings with people who accept her as she is may be the first constructive relationship she has had, the first healthy parental environment with authority and acceptance. The home's staff members may become "corrected" mother-persons, or unfortunately they, too, may be symbols of inadequate parent-persons. The girl's ego may be strengthened through identification with some staff members who become her ideal. This is revealed in such remarks as, "If I can only some day be half the lady Miss Y. is."

Acceptance and security in group living lessen tensions and help the unmarried mother to relax, thus freeing her to think and to make decisions. Carefully selected work assignments and constructive leisure-time activities give her an opportunity to discover talents and to learn new skills and to share these with others. School opportunities when available enable her to continue her formal education. In those maternity homes where positive religious values are stressed in helping to resolve fears, guilt, and anxiety, and in unifying the whole of living, group living means new spiritual values.

Practicing democracy and learning to accept authority are other aspects of group living mentioned in the material. Commented a young woman of superior intelligence when speaking of the interracial and interfaith aspects of group living, "Why can't the rest of the world learn to live together as we do in the maternity home?"

The extent to which an unmarried mother can involve herself in a responsible way in the give-and-take of group living, with the help of the caseworker and groupworker, determines its meaning for her.

### *Other Settings*

Some social workers regard these same aspects of group living, such as identification, companionship, and discussion with others—particularly about keeping or giving up babies—as reasons for not using a maternity home. Similarly they see the diversity of the group as to age, education, economic and social background, and other factors as negative points in a maternity-home setting. The answer to whether these are positive or negative factors probably depends on the quality of casework available within the maternity home, and how the caseworker helps in sorting out meanings and using the experience in total treatment. This is true especially in relation to the individual who is on the fringe of the group. The material shows that the maternity-home experience could be more meaningful through more and better casework and groupwork and more flexible policies regarding time of admission, length of stay, visiting and other privileges, and a more enriched program.

A place of acceptance, a place of security, a place of growing up in healthy group living—are these mean-

ings limited to a good maternity-home experience? Are these meanings always found in a good maternity home? Of course not. Can't the person experience these meanings in other settings? Why not? This article is not intended in any way to be a discussion of maternity homes in contrast to boarding homes or foster homes or wage homes or independent arrangements in rooming houses and apartments.

Whether to use the maternity home, or some other living arrangement for the person pregnant out of wedlock, depends on the resources available, the dynamics of the person needing service, and the skill of the caseworker in helping that person to determine what resources she wants and can use. It is interesting to note that in the material from social workers the same reasons are frequently given for choosing either a maternity home or a boarding home. The caseworker with her knowledge and skill and warmth helps the person to determine what she is looking for and to make the maximum use of the service available to meet her needs.

In the final analysis, I believe, the constructive use of a maternity-home experience revolves around the caseworker and other staff members who accept the person pregnant out of wedlock and are able to give of themselves fully in meaningful relationships to help her move toward more maturity. Given such caseworkers and other personnel in the maternity home and in the other community agencies, the maternity home can have much meaning in treatment.

Only with more diagnostic material and more valid histories can we more adequately identify, define, and evaluate deeper meanings and their relationship to total treatment. Until then, those of us who have the privilege and responsibility of offering maternity-home service can continue to increase our knowledge and skill to make the maternity home a place of acceptance, of security, of healthy group living. Such an experience can contribute to the well-being of the whole person, making it possible for the unmarried mother to say, as one respondent said: "Now I am well and ready to face life with my chin up."

<sup>1</sup> Young, Leontine: *Out of wedlock*. New York: McGraw-Hill, 1954.

<sup>2</sup> Littner, Dr. Ner: *The natural parent*. Paper presented at the National Conference on Adoption, sponsored by the Child Welfare League of America, January 26-29, 1955.

*Neglectful parents can often become good parents when their strengths are developed. Missouri helps them to do this through . . .*

## PROTECTIVE CASEWORK SERVICE

LORENA SCHERER

*State Child Welfare Supervisor, Division of Welfare  
Missouri State Department of Public Health and Welfare*

ALL ACROSS THE COUNTRY today aroused communities are initiating action to control and prevent juvenile delinquency. If their programs are to be effective, however, they must give increased attention to the provision of protective services to children in their own homes. In the broadest connotation such protective services include a variety of environmental and therapeutic services to safeguard the physical, mental, and emotional health of children, and to insure their well-being. Important among them is protective casework service—a direct casework service to parents not requesting help on behalf of their children who are not receiving minimum standards of care as determined by the community.

We know that a child has his best chance for physical, mental, and emotional growth and development by living with his own parents if they are reasonably mature, warm, and affectionate, physically healthy, and understanding of his needs.<sup>1</sup> We know too that not all parents can provide this opportunity to their children.

In 1943 the Child Welfare League of America published a report which constituted a survey of voluntary and public agencies giving protective services.<sup>2</sup> The survey showed there were "*greatly differing definitions of protective services which affected the intake and approach to families.*" The report could find no common ground in method other than "skills in protective services are drawn from generic casework supplemented by psychiatric knowledge." It concluded that "protective casework service is initiated when the community expresses concern for the welfare of a child."

Eleven years after the initial Child Welfare League study we still do not know the extent of protective casework service in practice, and there continues to be some division of opinion regarding the method of giving the service. For every year that passes in failure to provide protective casework services, more and more children will need care outside of their own homes. If we are not concerned about the mounting costs of such care then surely we must be concerned for what happens to the child in separation. Even at its best, it leaves its mark on his personality development. There is no question that protective casework service is both economically sound for the taxpayer and emotionally sound for the child and his parents.

Those who are engaged in protective casework services have a responsibility for defining their methods. They must do this in order to have a measurable service that can be evaluated and reevaluated qualitatively as well as quantitatively.

### *Authority*

Social agencies give protective services when they have a legal mandate or administrative policy, emanating from the board or the law, or both, *to protect children.* This carries with it a right to offer unsought help. Social workers in such agencies carry two types of authority: that which the community gives in law or board policy or both, and an *inherent authority* which is derived from their profession in being casework practitioners. They do not have the same authority as the judicial agency, which they sometimes may need to call upon in planning for the child.



The caseworker's authority is not dangerous if she is not afraid of it. In order to use it constructively, she has to examine her own reaction to authority. Sometimes the workers most afraid to use it are unconsciously the most authoritarian people. The caseworker must also look into her own feelings to learn why it might be painful for her to help a parent who does not want help.

Getting the right feel about protective casework service is not easy. For the caseworker to know what she is there for and be comfortable about it is a good beginning. Being self-analytic sometimes brings discomfort, of course, but social workers are in a profession where practitioners often grow and mature through periods of discomfort. The satisfaction of helping parents to become better parents and the resultant satisfaction the parents achieve in parental privilege and responsibility are worthwhile goals.

The remainder of this article describes protective casework as practiced in the Division of Welfare of the Missouri Department of Public Health and Welfare.

### *Complaints*

A protective agency first learns about the child's not getting minimum care from a complaint to this effect. The complainant may be anyone—a parent who is no longer a member of the family group, a relative, a neighbor, the county commissioners, the district attorney, the judge, a teacher, a nurse, a minister, a member of the agency's staff, another agency, or it may be read in or between the lines of an ADC case record.

However, agency policy determines from what source complaints will be received. For example some agencies accept complaints only from the juvenile court. In Missouri the Division of Welfare accepts all cases referred to it by the juvenile court as well as complaints from individuals in regard to families receiving public assistance.

In this way the agency knows that a child, or children: (1) lacks physical or health care; (2) is physically abused; (3) is exploited; (4) is exposed to an undesirable environment or association; (5) is without proper supervision from a responsible adult; (6) is so emotionally deprived that he has developed behavior symptoms. The agency also learns from the complaint that the parents have failed to do anything to remedy the situation.

It is very important for the caseworker to have specific information regarding the parents' failure to provide proper care for the child, as a basis for frank

discussion. It is not enough for her to say to the parent: "We have been told that you are neglecting your children and we are here to help you give them better care." This confuses the parent. The caseworker must begin with specifics such as: "We learned," through whatever source, "that you spent the last two weekends out of town and that the children were at home with no one to look after them. The complainant also tells us that the children are truant from school, and that you sometimes don't know what you are doing when drinking and whip the children severely with a strap."

It is necessary for the caseworker to have a valid and well-supported reason for entering the picture. The complainant must provide the proof that minimum standards are not being met and tell of the circumstances surrounding these conditions. It makes a difference if the complainant is judging lack of minimum standards of care from his own rather than the community's standard. If this is so, the agency tells him that service is given only if the community standard of care is unmet. In dealing with complainants the agency recognizes their genuine concern, helps them be specific about their complaints, explains its services and exhibits its own concern and sense of responsibility for the child.

When the complainant is another agency, that agency has a responsibility to tell the client that the complaint is being made.

When the client is told about the complaint treatment has begun, for the complaint challenges the parent to change. Treatment in social casework is composed of challenge and support constructively used and perfectly timed. In beginning with the complaint, the caseworker not only stirs the parent toward change, but also gives understanding and support.

When one parent living with the family makes a complaint about the other parent it is important for the caseworker to engage the complaining parent at once. Both parents are equally responsible for their children and thus both parents are responsible if one parent fails to give minimum care. The social worker can ask the complaining parent what he has done to help change the situation, thus stirring him to responsible action.

Too often in protective casework we forget the fathers and deal solely with the mothers. Both fathers and mothers are important. The caseworker may want to interview them together or separately depending on the situation, but she must get

over to them the togetherness of their responsibility in parenthood.

### ***Initiation of Service***

If social casework is to be meaningful, it must have focus and direction. The object of protective casework is the child, but the focus is on the parent—as a person, and as a parent. The concern is for the person, but the focus of treatment is on the parent part of the person. The caseworker begins with the symptoms which show the client's shortcomings as a parent, not as a person. If a neurotic mother rejects her child to the extent that he develops behavior symptoms the casework focus is on what the mother does with the child. The caseworker's purpose and goal in dealing with the mother is not to treat her neurosis but to help her become a more responsible parent.

When possible, service is best initiated through a letter to the parents identifying the agency and the caseworker, pointing to the community's and the agency's concern for the child, and calling the parents' attention to the fact they are not meeting minimum standards of care and inviting them to the office for an appointment.

The letter serves several purposes. It (1) identifies the agency; (2) gives a general explanation of the service and the community's concern; (3) introduces the reality that help is needed; (4) gives the parent a chance to react in privacy; (5) provides a means for stirring the parents; (6) gives the parents time to consider what to do.

The parent is offered an office appointment because this is usually less threatening than a home visit. The office interview gives him a chance to take the first forward step toward change. However, if it is physically or emotionally impossible for the parent or parents to get to the office, the caseworker visits the home after writing a letter to say she is coming.

If following a careful diagnosis and interpretation of casework services to the parents, the parents indicate that they do not want the service and cannot utilize it, the agency has no other recourse but to withdraw. If minimum care is not being given to the child and the limitations of the home for the child outweigh its strengths, the situation has to be referred to the juvenile court for legal action.

Time is a precious tool in casework. It is important that worker and parent talk over the time they will spend together. This setting of interviewing time, place and frequency is done in the first inter-

view, and is arrived at mutually. The caseworker may ask the parent: "How long do you think it will take for you to change the conditions that led to the complaint? Do you suppose that we can try this interviewing schedule, and in 3 months see how much has been accomplished?" It is essential that the caseworker periodically reevaluate the situation with her supervisor.

### ***Relationship***

Worker-parent relationship is the *most* important tool in protective casework services. In order to build a purposeful relationship the caseworker has to believe strongly that nearly all parents want to be good parents. She must know that in every human there is a "core of positives" that, if stimulated, helps him to achieve. She must believe deeply that people have the capacity to change, to develop, and to evolve.

Believing this with all her being as well as with her intellect, the caseworker then offers parents: warmth and kindness; understanding and acceptance as persons; respect for their individuality and personal dignity; outgoingness; strength and vigor; and hopefulness.

Although the caseworker gives parents understanding and acceptance as persons, she does not condone their behavior in respect to their children. In fact, she says, feels, and acts out—"I understand you, like you, accept you, know that you want to do the right thing for your child, if you could. I respect your individual dignity as a person; but I, as a representative of the community's concern for children, cannot accept what you do to your child."

To verbalize or accept this intellectually is not enough. The successful worker in protective casework service has to feel this and emanate this from her entire being. Only in this way can she truly accept the parent, regardless of the kind of care he gives the child. Only then can she help parents to take steps toward making outward or inward changes for the sake of their child. She must be aware that the parents themselves may have been denied adequate care and emotional acceptance.

### ***Treatment***

Treatment takes place through interviews in which the parents' problems, fears, and conflicts in relation to their child are discussed. It takes effect when the parents can accept the worker's, the agency's, and eventually the community's standard of child care. Neglectful parents are often hostile. Having often received rebuffs because of their behavior they react

hostilely. They often expect hostility and if they don't receive it, their fears on which their own hostility is based are diminished.

Often the caseworker may have to become the good parent to the parent. When such a relationship is used the caseworker must be alert to step out of the parent role as soon as possible to avoid perpetuating the dependency relationship too long. The good parent is nonsubmissive, nonjudgmental, and is kindly, firm, and consistent. A good parent is supporting, but not too supporting. He sets limits of unacceptable behavior. He is firm, but he controls his own hostility. He expects growth and self-reliance. The good parent-therapist helps the parent see and face facts and issues, and helps him to see choices and alternatives. Treatment is a corrective emotional experience and it is often a slow process.

Protective casework service begins with a consideration of specific facts showing the parents' deviation from the average of accepted parenthood, as the community sees it. These facts come from: the complaint; subsequent exploration; and an evaluation of the parents' previous experience with social agencies, if any. In considering this last it is important to learn: whether the parents were able to relate to the other agency constructively; whether they were able to use its services; what length of time they needed financial assistance or service; and whether they revealed any positive factors, such as strong family feeling, ability to focus on the problems and to understand their relation to their past, a desire for change, and ability to be self-responsible.

This other agency's evaluation gives some clue as to how a parent may use his experience with the agency. Even though the other agency arrived at a poor prognosis the caseworker continues to try. She does this because she knows that she has had success with some parents who were not able to use other agencies. She knows that the focus of the other agency may not have centered on responsible parenthood.

The caseworker gets her direction by listening to what the parent says. She lets the parent tell about himself, helping him to focus on the relation of his own history to his lack in parenthood. She is not interested in history for history's sake. She is interested in history if the client has a need to share his past, but she does not let the needle get stuck in the same groove. If a mother says that she cannot be a responsible mother because she never knew what it was to have a mother, the caseworker listens, understands, accepts the fact, identifies with it, but

brings the mother back to the reality of the task before her—learning to be a responsible mother. She remains a reminder of the ever-present reality factor for the parent.

### *Steps and Goals*

In treatment, the goals must be based in reality. The caseworker is not treating the total personality of the parent. She is focusing on the parent part of him and his potential for changing this.

From the parent the caseworker gets the clues for the steps the parent will need to take in correcting the situation. She begins where the parent is, not where she the caseworker is or where she would like the parent to be. She helps him sort and decide on alternatives in action. She talks about the down-to-earth specifics of the everyday business of parenthood.

The caseworker does not set the goals for the parent. The parent sets them for himself with the aid of the caseworker's challenge and stimulation. She helps him to decide on what conditions are good and right for his children. She helps him take the smallest step he can toward this. She shows her faith and confidence in him. She continues to widen his capacity by arousing his confidence in himself and stimulating his initiative.

In a certain rural county there were 12 children with a mother who appeared to be mentally limited. The father was intelligent and worked when he could. The case was referred by a nurse, public-health committee, neighbors, and public-assistance worker. The children were truant from school, the house was filthy. Every agency in the county had been in on the case in the past 10 years.

Father's weekly interviews were productive. Mother's separate weekly interviews were not as productive. Father thought the house and children could get cleaned up if they had water in the home. The caseworker asked him how to get water. Father said: "Dig a well." The worker said: "Who will dig it?" Father said he would dig it if someone would pay for the necessary equipment. The caseworker got the Farm Bureau consultation and community groups to pay for the equipment. Father dug. Step number 1 was taken with resultant satisfaction to father and mother. The children were cleaned up, and the community began to have more confidence in the parents.

The caseworker praises and encourages the parents for each step they take, stimulating self-satisfaction in their accomplishments. They begin to take pride and joy in being acceptable parents and often come to the interviews looking better, feeling better, and being better. The caseworker thinks, feels, and says: "I do have confidence in your ability to change; look what you have done. That is good. That is fine."



As caseworker and parent work together, the caseworker stimulates the parent to a conscious evaluation of his job of parenthood. She focuses on "what is it that is causing this difficulty in being a responsible parent?" rather than on "why aren't you a responsible parent?" When the parent has discovered what it is that keeps him from giving minimum care, and what he can do about it, he has developed some insight into his unconscious motivation, and can set up controls to help him cope with the difficulty.

### *Termination*

The agency terminates a protective service case when:

1. Change in the situation has taken place and the child is receiving care which is at least up to the community's minimum standards.
2. The service has been given for a period of time (12 to 18 months) and though little change has taken place the positive strengths of the parents in parenthood outweigh the negative factors.
3. After a period of time (varying with the situation) change has not taken place and the child's welfare is in danger. At this point the agency has no alternative except to go to the juvenile court. The court may ask the agency to continue service, or occasionally when it seems that bringing the case to court may help the parents face reality, the agency may recommend continued service to the parents through court action, or the court may place the children.
4. After a period of working together when the parent voluntarily requests placement and this appears to be for the best interest of the child and of the parents.

What goes into the decision to terminate a case? Termination really begins at the beginning in the caseworker's initial evaluation of the parent's capacity for parenthood and continues with parent participation. Directly or indirectly the caseworker continuously asks: What are your strengths? What are your capacities? Can we get to the positives in your potentialities? What steps can you take? What steps have you taken? How far have you come from those ways in which you were failing to provide minimum care?

The clues for termination must come from the parent as the case proceeds. These are indicated by the constructive changes he makes in his ways of providing care and by his increasing satisfaction in

the job of parenthood. There are clues in such remarks as: "When I think of how upset and nervous I used to get 3 months ago when Nan and Pat got into a fight, and how calm and really helpful to them I am now" or "The housekeeping was always drudgery, but now it's worth it."

If the caseworker keeps the case open longer than necessary, she really denies that she believes the parent has capacity and that change has taken place. Thus she may add to self doubts which the parent has about his ability to be a responsible parent. The aim is not to be a continuing supporting factor for the parent but to help the parent develop his innate capacity, out of his core of positives, toward satisfying responsible parenthood.

### *In Summary*

Protective casework is based on the premise that most parents want to be good parents, even if they are failing miserably. It means a great deal of understanding of what causes them to behave as they do; and what factors both outside and inside of themselves make them neglect their children. It means looking for the smallest ray of hope—the minutest positive in parenthood on which to build. It means tapering great expectations to fit the individual parent, which may turn out to be small expectations. It means genuine, heartfelt acceptance of the dignity and worth of the individual parent. It means acceptance of him as a person; but it does not mean condoning his behavior as a parent.

Protective casework requires a realistic redefinition of "the right of self determination," as applied to the parent. Can society afford to let a parent be self-directing, without help, if this self-direction interferes with the minimum standards of care every child needs for development toward eventual happy and responsible adulthood? Is it true that in life it is necessary to give up some measure of freedom to attain a greater and wider freedom? Do we really believe people have a capacity for flexing and changing? Such questions reveal the tremendous burden of responsibility on those social workers who by the very nature of their jobs may be required by law or agency policy, or both, to assist in the maintenance of the family unit for the protection of the child.

<sup>1</sup> Bowlby, John: *Maternal care and mental health*. New York: Columbia University Press, 1951.

<sup>2</sup> *Conferences on Protective Services Held in 1942*. Child Welfare League of America. 1943.

# A MILESTONE IN EDUCATION FOR SOCIAL WORK

ARLIEN JOHNSON, Ph. D.

*Dean, School of Social Work*

*University of Southern California*

EDUCATION for any of the professions has developed largely by the trial-and-error efforts of those practitioners who have had the zeal to impart some of the knowledge and skill they have acquired by experience. Traditionally, professional schools have frowned upon anyone teaching who has not first practiced with some degree of success. Similarly, education for social work has developed its standards through the leadership of practitioners who could apply to students some of the understanding of individual growth and development that they have made use of in service to clients.

Too much teaching in this field, however, is intuitive or patterned after teachers who have made an impression upon the person teaching.

The publication of Charlotte Towle's "The Learner in Education for the Professions"<sup>1</sup> marks a milestone for professional education as such. Here are gathered together the wisdom that comes only from experience and a body of principles that come from study, analysis, and generalization. Miss Towle has distilled from her experience as a practitioner and teacher of psychoanalytically oriented social casework those principles of learning which give maximum consideration to the capacity and movement of the learner. To these she has added the benefits of a lifelong study of education which began as an undergraduate student and was continued in collaboration with colleagues on the University of Chicago campus. All this has enabled her to generalize about principles of education in any profession, and specifically in social work, especially social casework.

To the educator an exciting aspect of Miss Towle's book is its affirmation of what one has learned from experience. It would be reassuring if it did no more

than show the universality of the "curve of learning": the plateaus and slumps that students experience with the subsequent spurt in achievement; the struggle that most students have as they let go of the old and take on the new under stress of growing self-awareness and insight; the preoccupation with self-activity that precedes ability to focus on the client and his activity.

Miss Towle's contribution is in underpinning these and other phenomena with a theoretical base about learning and with a body of generalizations about teaching. Although social casework is the part of the curriculum to which she applies these processes, the principles are relevant for all of education for social work and even for other professions. This is one of those all too rare books that integrate theory and practice.

The book is divided into two parts. Part I, on "Learning Process and Educational Process," lays the foundation for Part II, "Applications in Teaching Social Casework." No condensation of content could reveal the wealth of material presented. Therefore, only a few aspects will be commented on here.

## *Student Selection*

Today when applications to schools of social work are dropping, the selection of students is a critical problem. Miss Towle refers in many places to the need for "socially educable" students and devotes chapter 6 to selection. She points out that social work makes heavy demands on the learner to change, to relate to others, and to become able to function independently within the framework set by the profession.

It is true that criteria for educability are still ten-

tative, but we have learned a few things. Good intellectual capacity is fundamental for learning but high-grade point average alone does not provide evidence that the student is socially educable. The self-centered or neurotically inhibited student may compensate for social immaturity by concentrating on intellectual achievement. Too great deprivation in early life and no experience of a close relationship of mutual trust with another make a candidate a poor risk for a profession in which faith in another and ability to enter into close association with him are essential.

One can only agree with Miss Towle that we know more about the problematic learner than we do about the normal or highly productive one and that "potentials for growth and change as the individual is nurtured through a desired experience are not readily known out of context of the experience." But at this time when so many professions and trades are competing for the college graduate, schools of social work need to continue with more care than usual to study criteria for the socially educable lest they bring into the profession persons who are inadequately prepared or motivated to carry the responsibilities which are required. Admissions committees of schools of social work and agencies employing untrained workers would do well to read chapter 3, "Personality Development."

To help a student learn with due regard to his motivation and capacity is, of course, the aim of the teacher. How to do this is less obvious. Miss Towle has provided many leads in her discussion of "Educational Principles and Process" (ch. 5). Among them are: (1) individualization of the learner so that he learns with his "ego intact," with reorganization and integration, without disorganization; (2) provision of knowledge as a basis for doing—to know comes first; (3) arrangement of learning experiences so that they have continuity, sequence, and integration; and finally, (4) an educational relationship that sustains the student as he struggles to acquire knowledge and to discipline feelings related to it.

The book stresses the importance of distinguishing between therapy and education. Just as the student must learn the limits of his service to the client, so the educator must distinguish between those problems of learning for which it is his responsibility to provide help and those problems within the student's personality which call for help from another kind of specialist. While the relationship of the student is probably closest to the field-work supervisor and the faculty adviser, Miss Towle makes the point that

the total educational experience must be a positive and supporting one. The student has multiple relationships—to individual instructors, to the administrative officials of the school, to his fellow students. If all of these relationships confirm and reinforce one another, his learning is greatly facilitated.

### *Principles and Application*

There will doubtless be less widespread agreement about the applications of principles to teaching presented in Part II of the book than about the principles themselves. Here Miss Towle relies upon her experience in one school of social work. For example, while she concedes that social groupwork is "another treatment process" alongside social casework, she regards community organization as a part of the "organization and administration of welfare services" rather than as an aspect of "social treatment."

A contrary point of view would distinguish social community-organization work as a method from the field of community organization for social welfare. This approach would perceive patterns of behavior in the social institutions and resources which people develop and in the attitudes which they hold in common, and would assert that the social worker's function is working with people in their organized relationships to help them modify attitudes and resources and to create new ones. Whether designated as casework, groupwork, or community organization, social work is concerned with help to people in their problem-solving needs. The ends are products of the means whether the work is with intergroups, with primary groups, or with individuals.

One other criticism, which Miss Towle foresaw, is the amount of repetition that is occasioned by the book's organization as a collection of papers, each of which can be read alone, with the exception of three chapters. Perhaps Miss Towle's opinion that learning requires repetition may have affected its composition. While the reiteration enhances the reference value of the book it detracts from its readability as a whole.

Miss Towle has done a great service to professional education in making available her rich store of knowledge about its theory and practice.

With this book, we move ahead in social-work education.

<sup>1</sup> Towle, Charlotte: *Learner in education for the professions*. Chicago. University of Chicago Press. 1954. 432 pp. \$7.50.



## BOOK NOTES

**STUTTERING IN CHILDREN AND ADULTS**; 30 years of research at the University of Iowa. Edited by Wendell Johnson, assisted by Ralph R. Leutenegger. University of Minnesota Press, Minneapolis. 1955. 472 pp. \$5.

Addressed to speech pathologists, psychologists, special-education supervisors, physicians, and other professional workers and students, this collection includes more than 40 reports of research on stuttering.

The reports offer the results of study of a number of facets of the subject, such as the onset of stuttering, non-fluency of speech in stuttering and non-stuttering children, conditions under which stuttering varies in severity; personal adjustment of stutterers, physical approaches to stuttering, and therapy.

The most inclusive chapter discusses the relationship of parental attitudes and adjustments to the development of stuttering. In this connection, the editor of the book remarks that the problem of stuttering seems to start, not in the speaker's mouth, but in the ear of the parent or other authoritative listener.

**THE DYNAMICS OF CASEWORK AND COUNSELING.** Herbert H. Aptekar. Houghton Mifflin Co., New York. 1955. 262 pp. \$3.50.

In this book the author presents an approach to casework theory and practice which he believes integrates what are usually regarded as the two opposing theories of the diagnostic and functional schools of thought and practice. Explaining their origins and basic concepts, he suggests ways of combining the positives of each into a *dynamic* approach to casework and counseling. In doing so he presents and analyzes a tape recording of an interview in which such an approach has been used. The book concludes with a call for more "inductive research" carried out through similar analyses of cases from both diagnostic and functional schools in order to find out what caseworkers are actually doing. Social casework, the author

maintains, will not be really mature until the two schools of thought have become integrated into a truly dynamic concept focused on "change which produces change."

The book carries a brief introduction by Marion Hathway, its editor. The author's acknowledgments suggest that the manuscript was reviewed by a broad representation of social casework theoreticians and educators.

**AMERICAN INDIAN AND WHITE CHILDREN**; a sociopsychological investigation. Robert J. Havighurst and Bernice L. Neugarten. University of Chicago Press, Chicago. 1955. 335 pp. \$5.

Nearly a thousand children were studied by the authors with two major purposes: to find out as much as possible about their moral and emotional development and to devise a battery of tests which might be used by other workers in similar cultural studies. The report shows the results of tests given to six groups of Indian children—Hopi, Zuni, Navaho, Papago, and Sioux—and to a group of white children living in a typical Midwestern community.

An appendix compares the findings on the Midwestern white children with information obtained about 1,700 New Zealand children similarly tested.

The study was undertaken as part of the Indian Education Project of the Committee on Human Development, of the University of Chicago and the U. S. Department of the Interior's Office of Indian Affairs.

**HEARING THERAPY FOR CHILDREN.** Alice Streng, M. S.; Waring J. Fitch, M. D.; LeRoy D. Hedgecock, Ph. D.; James W. Phillips, M. D.; James A. Carrell, Ph. D. Grune & Stratton, New York. 1955. 371 pp. \$6.75.

To help members of professional groups who work with children handicapped by loss of hearing, the authors present information on causes of hearing losses and their medical treatment;

case finding, clinical audiometry; hearing aids; and education of children with different amounts of hearing loss. An appendix lists established hearing rehabilitation centers in the various States.

**CHILD DRAMA.** Peter Slade. Foreword by Dame Sybil Thorndike. Philosophical Library, New York. 1955. 379 pp. \$10.

Emphasizing that *drama* is "what you do," as opposed to *theater*, which has come to mean "what you sit and watch others do," the author of this book shows how child drama, born of play, "can be nurtured, guided, and provided for by the wise parent and the able teacher."

The book offers practical suggestions for encouraging spontaneous drama—including art and music—among children from infancy through the age of 15. Though much of the book is addressed to teachers, the author makes clear that child drama outside of school is just as important as it is in school.

**SPECIAL EDUCATION FOR THE EXCEPTIONAL.** Merle E. Frampton and Elena D. Gall, editors. Porter Sargent, Boston. 1955. Three volumes: Vol. 1, Introduction and Problems, 453 pp.; Vol. 2, Physically Handicapped and Special Health Problems, 677 pp.; Vol. 3, Mental and Emotional Deviates and Special Problems, 700 pp. \$5.50 per volume.

Planned as an introduction to the field of services for exceptional children and adults, these three volumes offer a description of such services, with emphasis on education, and many references for further study.

Volume 1 discusses the general field of special education and summarizes problems and methods common to all its phases. Volume 2 focuses on the physically handicapped—those with defects of sight, hearing, and speech; the orthopedically crippled; those with heart disease or rheumatic fever, Hansen's disease, muscular dystrophy, or tuberculosis; and those with multiple handicaps. It includes material on the homebound and the hospitalized. Volume 3 treats the subject in relation to the neurologically impaired, the epileptic, the emotionally disturbed, and the mentally handicapped. It also discusses the intellectually gifted.

# PROJECTS AND PROGRESS

## *The Polio Vaccine*

Although less than 9 months have elapsed since the effectiveness of the Salk poliomyelitis vaccine was first announced, more than 10 million children and expectant mothers have already received vaccinations, and organized programs for giving the vaccine on a priority basis are now operating in 54 States and Territories.

Preliminary reports on the effectiveness of the vaccine, based for the most part on children who had received only one injection, indicate that the attack rate of paralytic polio among the unvaccinated is two to five times greater than among the vaccinated. Even more encouraging results are expected as children receive the full dosage of three injections. All States and Territories and more than 40 virus laboratories are cooperating with the Poliomyelitis Surveillance Unit of the Public Health Service in conducting these evaluation studies.

Progress of the program has been somewhat handicapped by limited supplies of vaccine and by the tragic aftermath of two early defective lots. However, improvements in testing methods, which were first revised in May and again in November, now assure consistent production of safe vaccine.

Except for a small amount of vaccine which was distributed commercially, all of the early supplies were channeled to the National Foundation for Infantile Paralysis, which offered to provide two injections, free of charge, to all children who were in first and second grades in the spring of 1955. By late fall, this program was virtually completed, with almost 7 million children—three-fourths of all who were eligible—participating.

Plans for providing vaccine for the most susceptible groups who were not covered by the National Foundation program were launched last April, when a National Advisory Committee on Poliomyelitis Vaccine was appointed by the Secretary of the Department of Health,

Education, and Welfare. Comprised of representatives of the medical and public-health professions, the drug industry, and the public, the Committee developed a voluntary-control system under which all vaccine, other than that used by the NFIP, is distributed to the States.

Under this system, a priority group is recommended by the National Committee and each producer agrees to ship into each State that proportion of each release of vaccine which corresponds to the proportion of unvaccinated persons in the priority group residing in the State. The allocation is made by the Public Health Service on the basis of data furnished by the vaccine manufacturers and by the States.

Distribution within each State is planned by the State health department in cooperation with a State advisory committee. Each State decides how much of its vaccine will be distributed through normal commercial channels to physicians and how much will be reserved for public agencies. Each State also decides what groups will have priority. Most States follow the National Committee's recommendation on priority, which was originally limited to children aged 5 through 9 but was expanded in October to include all children under 15 and expectant mothers.

To help States finance poliomyelitis-vaccination programs, Congress passed the Poliomyelitis Vaccination Assistance Act on August 12. This authorized grants to States for purchase of vaccine and administration of programs. Out of the initial appropriation of \$30 million, \$25 million was earmarked for purchase of vaccine and about \$5 million could be used either for vaccine or for administrative costs. In addition \$4.5 million of the general health-grant appropriation was earmarked for administration of polio programs.

By the middle of November, 54 States and Territories had applied for vac-

cine grants and were operating under plans approved by the Public Health Service. To meet Federal requirements, these plans provide that the vaccine will be used only for children under 20 and expectant mothers and that, in public programs, no means test will be used to limit eligibility.

Most States depend on local communities to develop detailed plans for use of the vaccine. The prevailing pattern is to make the publicly purchased vaccine available both to private physicians (who may charge for services) and to public clinics (where both vaccine and service are free). In a few States all vaccine is purchased with public funds; in some others, no publicly purchased vaccine is distributed to private physicians; but in most States, private physicians can obtain vaccine from both commercial and public sources.

Shortage of vaccine is now the major obstacle to mass vaccinations. A proposal to stretch the supply by limiting each eligible person to one injection of one cubic centimeter was considered in December by a group of medical and public health authorities called together by the Surgeon General of the Public Health Service. The proposal was rejected, however, on the grounds that the immunity one injection provided might not last through the next polio season.

The schedule unanimously endorsed by the group calls for two injections of one cubic centimeter each, the second following 4 to 6 weeks after the initial dose (or as soon thereafter as possible). Seven or more months later, a third "booster" shot should be given.

## *Crippled Children*

About 3,000 persons with cerebral palsy received services from 165 public or voluntary agencies—medical, educational, or social—in New York City in 1954, according to the Coordinating Council for Cerebral Palsy, a local voluntary agency. An additional 103 agencies offered such services, but had not served any cerebral-palsied persons during the year of the survey. The largest number of persons were served by public agencies—the city department of health and board of education and the State department of education.

While the total number of cerebral-palsied persons in the city is not known, the city health department's bureau of

handicapped children estimates the figure at 12,000 to 19,000. The Council recommends that efforts be continued to establish an unduplicated register of the cerebral-palsied to help in planning services.

The Welfare and Health Council of New York City, with the help of the Association for the Aid of Crippled Children, has begun a 3-year research study to demonstrate how handicapped and nonhandicapped children and youth can be helped to engage in joint activities in community centers, settlements, and camps.

Special rheumatic-fever and cardiac clinics are carried on in more than 600 communities in the United States, representing about 90 percent of the population of the country. More than half the clinics are sponsored by official agencies.

Ohio's State Legislature recently rescinded a requirement that a court commitment was necessary before a child could receive services under the crippled children's program. Ten States still have such a requirement.

The American Public Health Association's Committee on Child Health is issuing a series of guides for agencies and organizations concerned with community services for children with various handicaps. The first of the series, entitled "Services for Handicapped Children," sets forth general principles and practices. The others, some already published, will illustrate their application in planning services for children with specific disabilities. These include: cerebral palsy, cleft lip and cleft palate, dentofacial handicaps, diabetes, emotional disturbances, epilepsy, hearing impairment, heart disease and rheumatic fever, orthopedic and neuromuscular handicaps, and visual impairment and other eye problems.

After a child has passed the acute phase of rheumatic fever his own home is in most instances a good place for him if housing and nutrition are adequate, the emotional atmosphere is favorable, and community agencies are available to provide the services he needs, according to "Standards for General Convalescent Homes Caring for Cardiac Children," a 20-page guide

to communities planning convalescent-care programs, recently issued by the American Heart Association. While it outlines the essentials of a well-rounded program for a convalescent home, the guide advocates a review of total community resources and needs before planning to build such a home, particularly in view of the fact that the incidence of rheumatic fever is decreasing. Available to professional persons on request, from the Association, 44 East 23d Street, New York 10, N. Y.

### *United Nations Action*

At its last meeting the General Assembly of the United Nations increased the funds available for the program of advisory social-welfare services to governments for 1956 and the following years. The amount voted was \$1 million.

The action was taken at the suggestion of the Economic and Social Council, on recommendation of the Council's Social Commission, for providing a significant increase in resources for these services.

The Council has also approved the Commission's recommendation that a small group of experts be established to study maintenance of family levels of living through social insurance, social assistance, and related social services. Another of the Commission's approved recommendations suggests that official and voluntary agencies in member nations increase training facilities and programs for social workers.

The Secretary-General of the United Nations recently reported that between 1950 and 1954 the number of schools of social work throughout the world increased from 335 to 432.

### *World Health*

As a step toward eradicating malaria from the Western Hemisphere, a coordinating office for various governments' malaria programs has been established by the Pan American Sanitary Bureau, the World Health Organization's regional office for the Americas, with headquarters at Mexico City. The governments are emphasizing the necessity of attacking the malaria-carrying mosquito, anopheles, on a broad front before it develops resistance to such insecticides as DDT.

Other current WHO campaigns in the Western Hemisphere are aimed against yaws, smallpox, venereal dis-

eases and yellow fever. In addition a number of projects are focusing on environmental sanitation, tuberculosis control, maternal and child health and nutrition.

In mass campaigns against yaws, governments of 28 countries in various parts of the world, with the help of WHO and the United Nations Children's Fund, have examined 40 million people since 1948 and have treated 10 million with penicillin. This disease, which begins in childhood, destroys the skin and bones and often affects the face, body, legs, and arms.

The cost of examination for yaws is reported by WHO as 10 to 20 cents per person, and the cost of treatment as 30 to 80 cents. Some governments have organized their campaigns so effectively, according to a WHO report, that each field team of 6 to 10 workers can examine as many as 25,000 persons a month.

In preparation for a technical discussion of educational requirements for entering nursing schools, scheduled for the Ninth World Health Assembly, to be held June 1956, nursing associations in all member countries of the World Health Organization are surveying nursing resources.

### *School Health*

A group of Pennsylvania schools that used a visual-reminder device to keep track of progress toward getting medical correction of children's defects showed a one-third higher correction rate than a control group that used ordinary followup methods, according to the report of a study published recently by the Health Education Foundation. Financed by the Foundation, the study was made by the Social Science Research Center of Pennsylvania State University.

When a routine spring health examination of about 1,700 third- and fifth-graders in 20 schools had revealed defects requiring medical attention in more than 450 children, school nurses followed up each case, telephoning and visiting parents to persuade them to take their children to a physician.

In 15 of the schools the nurses kept track of the results with the help of an individual record card for each child, on which colored tabs showed at a glance what defects needed medical at-



tention, what contacts the nurse had made, and whether or not the parents had taken the child to a doctor. Nurses in the 5 control schools made the usual efforts to get parents to act, but did not use the visual reminder.

Three months later, in the 15 schools that had used the reminder card the correction rate was found to be 60.7 percent; in the 5 control schools, 45.6 percent.

Similar results were not obtained, however, with dental defects. The schools that used the visual device to check progress in correcting dental defects obtained no better results than the schools in the control group.

## *Juvenile Delinquency*

After collecting information relating to juvenile delinquency from a number of Indian reservations the Subcommittee to Investigate Juvenile Delinquency, of the Senate Committee on the Judiciary, recently recommended steps toward prevention. These were:

That community-organization workers be employed on the reservations.

That in cases of illegitimate birth, law-enforcement officers should work to establish the child's paternity and to obtain support for him.

That child-welfare services be enlarged and improved with the help of special Federal appropriations.

That public-health measures be greatly extended.

That the States assume responsibility for the mentally ill, and that the Bureau of Indian Affairs enter into agreement with States to this end as rapidly as possible.

That a program of scholarships be developed for Indian youth, similar to the educational provisions under GI benefits.

That special vocational and technical courses be instituted in both public and Indian schools, for both adults and youth living on Indian reservations.

After conferring with a committee of the National Council of Juvenile Court Judges, the U. S. Department of Defense recently liberalized its policy on permitting persons with juvenile-court records to enlist in the Armed Forces. Instead of requiring an applicant to wait 6 months after his probation has been completed before accepting his application for enlistment, the Depart-

ment now passes on his fitness for the armed services at the time of his application for enlistment. If the applicant is not under civil restraint, if his overall rehabilitation appears to be satisfactory, and if he is otherwise qualified for service, he is permitted to enlist.

As a step toward meeting the serious need for trained personnel to work with juvenile delinquents and adult offenders, the Rosenberg Foundation of San Francisco is contributing \$20,000 toward the support of a 6-week summer course at the University of California, Berkeley, in 1956, designed to provide social-work teachers with an educational experience focused on the correctional field. The course will be offered jointly by the University's School of Social Welfare and the Children's Bureau.

Twenty-five social-work teachers and potential social-work teachers are being selected to be students of this course by a committee representing the University of California's School of Social Welfare, the Children's Bureau, the National Probation and Parole Association, and the Council on Social Work Education, from nominations made by deans of schools of social work or executives of correctional agencies.

The course will focus on sociological and historical analysis of the correctional field, adaptation of social-work treatment methods to correctional practice, and educational problems in social-work training of correctional personnel. All students will receive field-work placements in correctional agencies and will have opportunities to meet leaders in the correctional field in informal group discussions.

Students of the course will receive reimbursement for expenses incurred by their attendance.

## *Child Guidance*

Financed by several foundations, a 2-year survey of the Bureau of Child Guidance of the New York City Board of Education has been conducted under the auspices of the Board by an advisory committee representing four disciplines—psychiatry, psychology, social work, and education; the administration of the city schools; and community groups.

In an effort to find out how and where the Bureau, whose current ratio of

workers to school children is 1 to 5,000, could render greatest service and whether changes would make its work more effective, the committee studied the services it provides, in the light of the budget and the size of the staff. Its recommendations are included in a recently issued report, "The Bureau of Child Guidance in New York City Schools." Among others, they include:

Expansion of social-work and psychological services, with psychiatric consultation to help teachers and principals with the increasing number of children needing help.

Expansion of the psychiatric service as a resource in caring for children with "severe, intractable, and emergency problems."

Creation of a clinic service to provide intensive treatment for selected children needing it.

Establishment of a research and development unit to collect and analyze service statistics and to provide technical aid in research.

Substantial expansion of staff.

Establishment of a broad program of inservice training for teachers, with emphasis on mental health.

Better liaison with other agencies and bureaus concerned with emotional and behavior disorders of children.

## *Adoption*

One in five of New York City's dependent and neglected children now in foster care is adoptable, if the more than 4,000 children recently studied by a committee of the Welfare and Health Council of New York City are a representative sample of the 14,585 children in foster care in the city.

Fourteen voluntary social agencies furnished information to the Council about the 4,031 children studied—practically all of them public charges now living in boarding homes or institutions. The agencies reported that one-fifth, or 773, of these children would benefit from adoption in the opinion of caseworkers who were in close touch with them. According to these caseworkers adoption would not be a sound plan for the remaining four-fifths.

Noting that race and age often stand in the way of a child's adoption, the committee points out that more than half of the 773 children considered adoptable are over 7 years of age and 63 percent are children of minority backgrounds.

Among other factors keeping many of these children from adoption, according to the committee, are the city's lack of a comprehensive program of adoption resources and the legal complications connected with the surrender of a child.

In its report, "Children Deprived of Adoption," the committee urges establishment of a public adoption service and of more workable legal machinery and improvement of casework services.

### *Mental Problems*

The National Institute of Mental Health and the National Institute of Neurological Diseases and Blindness, Department of Health, Education, and Welfare, have expanded their work in mental retardation as the result of appropriation by the 84th Congress of \$750,000 for this work in the fiscal year ending June 30, 1956. The Institute of Neurological Diseases, which received \$500,000, is concentrating on basic research on the causes and prevention of brain damage. The Institute of Mental Health is concerned with emotional, psychiatric, psychosomatic, psychological, and socioeconomic factors.

With a \$50,000 contribution from a Philadelphia pharmaceutical company the National Association for Mental Health plans to step up its efforts to mobilize citizen support against mental illness. Specially assigned staff, working in cooperation with the Association's 33 State member groups and 425 local affiliates, will concentrate on strengthening and expanding community services for mental health, establishing new State associations, and increasing the number of local affiliates.

New York State's joint legislative committee on mental retardation, created by the 1955 legislature with an appropriation of \$35,000, is investigating mental retardation in the State—its extent, and the social, educational, economic, mental, and physical problems.

### *Here and There*

Children and youth received major attention from the 1,600 delegates attending the first convention held by the newly merged American Federation of Labor and Congress of Industrial Organizations. In resolutions adopted December 7, 1955, the organization urged strengthening programs of maternal and

child-health services and special welfare services for children, including aid to crippled children. The resolutions also urged further research and education in child life to help parents understand better what makes for healthy, happy childhood, and improved procedures for spotting and aiding maladjusted children and to handle constructively those who get into trouble with the law.

The relation between social science and parent education is the subject of a 3-year research program recently begun under the joint sponsorship of the Russell Sage Foundation and the Child Study Association of America. New York University's department of sociology and anthropology is cooperating in the study.

Because aspirin kills more than 50 children a year and makes many more ill, the Food and Drug Administration, U. S. Department of Health, Education, and Welfare, recently requested manufacturers to label aspirin packages with a warning, such as "Warning—Keep out of the reach of children."

Twenty-five pediatric centers are co-operating with the Public Health Service and the National Tuberculosis Association in the first large-scale, controlled study using an antimicrobial drug as a prophylactic agent against tuberculosis.

Misunderstandings about adoptions are explored by Dr. Martha M. Eliot, Chief of the Children's Bureau, in a series of five articles recently released by the Bureau in mimeographed form. Single copies are available from the Bureau without charge.

"Rainbow Round the World," a story about the United Nations Children's Fund (UNICEF), by Elizabeth Yates, has won the 1955 Jane Addams Children's Book Award, given by the Women's International League for Peace and Freedom.

### *Facts and Figures*

About 7 in 10 of the Nation's 20 million families with one or more children of their own under 18 in 1950 were married couples with the husband under 45 years of age; about 7 in 100 were broken families. These facts were revealed by special tabulations of a

sample of the 1950 census returns for primary and secondary families, recently prepared by the Bureau of the Census, Department of Commerce.

Three-fourths of the married couples with the husband under 45 years of age had at least one child under 18 and about 1 in 5 had three or more. Of the families with a female head other than a widow, almost two-thirds included one or more children of their own and 1 in 6 had three or more.

Between the date of the 1950 census and April 1954, the number of husband-wife families rose by an estimated 5 percent; other families with male heads, by 13 percent, and families with female heads, 4 percent. During the same 4-year period the total number of children under age 18 in the United States increased by 14 percent—from close to 47 million to almost 54 million.

Farm households in the United States have been decreasing in number at a rate of about 150,000 a year during the last 5 years, and nonfarm households have been increasing by about 1,000,000 a year during the same period. These estimates by the Bureau of the Census are based on results of annual surveys, the most recent of which was conducted in April 1955. In that month there were 47,800,000 households in the United States—an increase of 4,200,000, or about 850,000 a year, since a comparable survey in March 1950.

Women 15 to 59 years old in the United States who had been married by 1950 had borne an average of slightly more than two children, according to a July 1955 report on the 1950 census published by the Bureau of the Census, Department of Commerce. Farm women had averaged 3 children; city women, 2. For rural women not living on farms the average was about halfway between the farm and the city averages.

Last fall's enrollments in public and private schools and colleges in continental United States are estimated at 39,557,000 by the Commissioner of Education, Department of Health, Education, and Welfare. The increase over last year's enrollment in kindergarten through eighth grade is estimated as 1,300,000; in ninth through twelfth grades, 7,422,000; in colleges and universities, 2,740,000.

# READERS' EXCHANGE

## THORNHILL: Confirmation

The excellent article, "Unprotected Adoptions," by Margaret A. Thornhill (*CHILDREN*, September-October 1955) was of particular interest to me because the Senate Subcommittee to Investigate Juvenile Delinquency is currently making a study of interstate adoption practices. Public hearings were held on this subject in Chicago on July 15 and 16, 1955. In addition, a national survey has been conducted by this Subcommittee on interstate adoptions arranged by unauthorized individuals.

The facts thus far uncovered confirm the position taken by Miss Thornhill in her article—that the roots of the black market, and most of the abuses in the adoption field, can only be eradicated by the improvement of services to the unmarried mother, the adopting parents, and the child.

One of the cases brought to my attention during the investigation highlights the direct connection between inadequate adoption services and poor placements. A juvenile court in the South has been making large-scale placements since 1946 throughout the United States. The community in which the court is located is almost completely lacking in adoption services; therefore, the court has played the role of an adoption agency.

In one instance, a 6-year-old boy who had lost his mother was sent to California for adoption. There had been no investigation by the court of the adoptive home. It developed that the prospective adoptive couple wanted this child to replace their 6-year-old son who had recently died. They quickly became dissatisfied with the second little boy and he was transferred to another couple who thought they wanted a child. This second family changed its mind after 2 years, and transferred the little boy to a third family. By this time, the youngster was so maladjusted that he was difficult to control. He eventually tried to kill his third foster mother by putting a poison substance into her coffee. At present, he is in an institution.

This case illustrates the need for a preplacement study of the child and

adoptive home, particularly in instances of interstate adoptions.

Our preliminary findings showed that:

1. The greatest abuses involving the interstate and intrastate placements of children for adoption occur in areas where there is a gap in child-welfare services.

2. Unmarried mothers are often compelled by the lack of services to use facilities of the black market.

3. There is a substantial amount of commercialized placement of children across State lines that warrants serious consideration of Federal legislation to eliminate this practice.

The greatest need, however, is an accurate and systematic assembling of facts relating to interstate placements. It is difficult to remedy a situation until all the facts are assembled. Once there is a dissemination of facts about a troublesome situation, the community, on its own initiative, can often rectify the problem. In Chicago, the subcommittee's investigation brought to the attention of public officials certain dangerous adoption practices in their courts. As soon as these practices were brought to light, they were immediately corrected by court officials.

Although some regulatory legislation may be necessary to strike at the baby racketeer who is operating across State lines, I feel that the greatest service the subcommittee's investigation can render to the community is the highlighting of the facts in the interstate adoption picture. Once this is done, I feel confident that the need for improved services on a local scale will be firmly established, and that the improvements will come on a local level without the need for extensive State or Federal legislation.

*Estes Kefauver*

*United States Senator*

## ALBEE: A different focus

I am particularly interested in "Group Work With Hospitalized Children," by Constance Impallaria Albee (*CHILDREN*, November-December 1955), since my work is with both out-

patients and bed patients in a pediatric hospital where I have been given the opportunity to institute a program with somewhat similar aims.

However, we have planned our program with a different focus. We have offered the help to hospitalized children on a prescription basis so that the child does not have a choice as to whether or not he enters the program but is, so to speak, ordered into the program. Our experience has been that the child quickly adjusts to the environment and we have had only one child in the 18 months' experience who has been even moderately resistant. Our goals, although in some areas confluent with those described in Mrs. Albee's article, vary in others. There are three focuses: prophylactic for children facing long-term hospitalization; diagnostic, for those children who enter the hospital with difficulty or perhaps who have already acquired problems within the hospital setting; and therapeutic, for those children who remain for a prolonged period.

Many children in pediatric hospitals remain for months, even years, because of orthopedic, cardiac, and other chronic problems. We find that the peer group gives the child an opportunity to exhibit his behavior in relation to his peers as well as to the adult, and, as has been pointed out by others, affords an excellent diagnostic opportunity. The same situation may be utilized in ongoing therapy.

Our program concentrates on the individual within the therapy groups. To be sure there is often a wide overlapping. It is evident from our work, as well as from Mrs. Albee's, that the education of the groupworker in addition to his routine groupwork training must encompass understanding of the individual. The groupworker should understand the psychodynamics of children well enough to pick up deviations and evidences of disturbance. This is valuable to the worker in designing the program so that the individual child may benefit from it therapeutically.

We have been conducting groups of the type described for about a year and a half and are persuaded that they should be continued. It is important to have a careful social study of the family beforehand or as the child is brought into the group; moreover, it becomes increasingly evident that a followup, especially for those children who come



from poor cultural and poor economic backgrounds, such as those on clinic service, should be available through a family-centered project.

*Henry H. Fineberg, M. D.  
Director, Child Guidance Clinic  
Children's Memorial Hospital  
Chicago*

#### BECK: The place of values

I have deep conviction of the importance of continued emphasis and reemphasis on the crucial part which cultural values play in the etiology and treatment of delinquency, as well as other forms of child maladjustment problems. To round out Mr. Beck's observation ("The Exiled Delinquent," by Bertram Beck, *CHILDREN*, November-December 1955) not only is the stress on "aggressive, individualistic competition in conflict with the ethical and social values which we teach children," but delinquency may very well be an unavoidable byproduct of an individualistic social organization.

Dean Kirchwey, who taught courses on criminology at the New York School of Social Work for many years, often spoke of delinquency as the price which a pioneer society paid for its enterprise and material progress. Similarly today we can see delinquency as the price exacted by rapid social change or "progress."

What I believe to be important is that, having recognized the interconnection between cultural and social factors in individual maladjustment, we do not content ourselves with merely improving the procedures which courts, institutions, and other correctional and treatment agencies employ, important though these may be. At the same time, we must do what we can to make sure that human values receive full consideration in all planning which influences the lives of people.

Lewis Mumford has for many years called attention to the importance of social considerations in city planning and construction. At the moment a commission is actively involved in planning improved transportation facilities for the New York metropolitan area, an area which holds one-tenth of the population of the Nation. It would be interesting to know how far factors bearing on healthful family life, constructive relationships between parents and children, rich neighborhood life, closeness to the soil, are given weight in this com-

mission's planning. I think it is fair to say that up to now much of our community planning has moved from partial and fragmented functional bases rather than from integrated social patterns in which human values are accorded the place they deserve.

Professional workers engaged in the field of social relations, including social workers, must get together and spell out as clearly as possible some of the essential values in family and child life which must be conserved and strengthened, and then persistently knock at the doors of all the individuals and groups who, in different ways, shape the pattern of our common life.

*Herschel Alt  
Executive Director  
Jewish Board of Guardians  
New York City*

#### VAUGHAN: As New York does it

At the Bureau of Child Guidance, which is part of the New York City school system, we have seen similar anxieties aroused in school personnel by clinical staff to those cited by Dr. Vaughan in his valuable description of Massachusetts efforts toward a total mental-health program. ("Mental Health for School Children," by Dr. Warren T. Vaughan, Jr., *CHILDREN*, November-December 1955.) To orient new staff, we explore with them not only the probable anxieties of teachers, but also their own as they face again the authoritative figures of their childhood.

With us, also, the school refers its most difficult cases first. Only if teachers get diagnostic and treatment service for these, can they see value in using consultation for less disturbed children.

Dr. Vaughan states that in Massachusetts treatment is carried on in mental-health centers, because "psychiatric treatment functions cannot be properly carried out in school settings." In general, we would agree. However, in our school system of nearly a million children, we have found it helpful to place all the mental-health functions in the school system.

We have Bureau centers which are part of the school system, but not administratively attached to a school. From these centers workers fan out to their assigned schools. As they become integrated into the school and its community, school psychologists and school

psychiatric social workers work increasingly with parents and children right in the school, going back to the centers for psychiatric consultation, and bringing into the centers cases for psychiatric diagnosis and treatment. It is true that under such a system skill and patience are required to separate the clinical functions from those of the dean's or the guidance counselor's office; but it can be done if each professional discipline has competence in and conviction about its role.

*Rose Goldman  
Chief School Psychiatric Social  
Worker, Bureau of Child Guidance,  
Board of Education, City of New  
York*

#### PERIODICALS: A common oversight

It seems most unfortunate that many social workers seem sometimes to resent the role of the juvenile-court judge, and likewise, perhaps, some juvenile-court judges resent the role of the social worker.

Undoubtedly some of the misunderstanding may come from the fact that judges of family courts operate under strict rules of law which they must construe and administer as they find them. Social workers, on the other hand, as members of social-welfare organizations, operate under "policies," which can be easily changed or revamped to meet different situations.

Many members of these groups do not understand the limitations or characteristics of these respective fields. Yet there is now a growing feeling that the existence of juvenile courts is necessary to protect the constitutional rights of children and their parents and at the same time the services of professional social workers, on the other hand, are generally respected and made use of by the better type of family-court judges. However, in many modern periodicals covering the work of social agencies and welfare of children, the work of juvenile courts, and the thinking of juvenile-court judges, are too often entirely overlooked or neglected, when they might make a valuable contribution out of their wealth of experience.

Why not give juvenile-court judges a little more opportunity to be heard, and to help plan needed facilities in the field of child welfare and rehabilitation of problem youth?

*Walter H. Beckham  
Judge, Juvenile and Domestic  
Relations Court, Miami, Fla.*

## SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

**PRENATAL HEALTH EXAMINATION LEGISLATION**; analysis and compilation of State laws. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. 369. 1954. 55 pp. 25 cents.

This publication reproduces the sections of the State and Territorial laws requiring prenatal blood tests for syphilis.

**SURVEY OF YOUTH FACILITIES AND PROGRAMS IN CERTAIN LOW RENT HOUSING PROJECTS OF THE PUBLIC HOUSING ADMINISTRATION (BY FIELD OFFICE)**. Housing and Home Finance Agency, Public Housing Administration, Office of Special Assistant to the Commissioner (Racial Relations). 1955. 79 pp. Single copies from the Public Housing Administration without charge.

Recreation services and facilities for children 6 to 18 years old in 51 housing projects to which people of racial minorities have access are described in this survey. Some of the projects are completely segregated; others have some form of integration in occupancy and activities. For each project the report specifies types of programs of-

fered; social agencies that have helped with them; benefits to the children, the project, and the community; and what needs to be done. The projects are located in 26 cities in 22 States.

**EMPLOYMENT CERTIFICATES—HELP YOU HELP YOUTH**. Department of Labor, Bureau of Labor Standards. Bulletin 183. 1955. 23 pp. Single copies from the Bureau of Standards without charge.

Addressed to all who have any part in issuing employment and age certificates, this bulletin discusses the relation between certificates and enforcement of school-attendance and child-labor laws, explains procedures generally found effective in making certificates serve their intended purpose, and describes the kinds of services given applicants in some issuing offices which might be available to all young people who need them. It also presents a guide for issuing certificates under the child-labor provisions of the Fair Labor Standards Act.

**ILLNESS AND MORTALITY AMONG INFANTS DURING THE FIRST YEAR OF LIFE**. Selwyn D. Collins, Katharine S. Trantham, and Jose-

phine L. Lehmann. Department of Health, Education, and Welfare, Public Health Service. Public Health Monograph No. 31. PHS Pub. No. 449. 20 pp. 15 cents.

Data obtained through household canvasses are supplemented in this report by information from official records showing trends of total infant mortality in the birth-registration States for 1915-53; trends for 1927-51 by sex, age, and geographic section; and mortality for 1950 by sex, age, and cause.

**ACQUIRING SURPLUS PROPERTY FOR HEALTH OR EDUCATIONAL USE**. Office of Field Administration, Department of Health, Education, and Welfare. 1955. 15 pp. Single copies available from the Office without charge.

This guide explains how eligible groups can acquire Federal surplus real or personal property for health or educational use, under the Federal Property and Administrative Services Act. It lists the addresses and telephone numbers of the seven regional property coordinators and also of the State directors of surplus property.

---

### Photo Credits

Frontispiece and page 14, Leon Levinstein.

Page 19, Westchester County (N. Y.) Department of Health.

---

**CHILDREN** is published by the Children's Bureau 6 times a year, by approval of the Director of the Bureau of the Budget, September 22, 1953.

**NOTE TO AUTHORS**: Manuscripts are considered for publication with the understanding that they have not been previously published. Appropriate identification should be provided if the manuscript has been, or will be, used as an address. Opinions of contributors not connected with the Children's Bureau are their own and do not necessarily reflect the views of **CHILDREN** or of the Children's Bureau.

Communications regarding editorial matters should be addressed to:

**CHILDREN**  
Children's Bureau  
U. S. Department of Health, Education, and Welfare  
Washington 25, D. C.

Subscribers should remit direct to the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

**CHILDREN** is regularly indexed by the Education Index

UNITED STATES GOVERNMENT PRINTING OFFICE, WASHINGTON 25, D. C. 1956  
For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.  
Price 25 cents a copy. Annual subscription price \$1.25  
50 cents additional for foreign subscriptions

UNITED STATES  
GOVERNMENT PRINTING OFFICE  
DIVISION OF PUBLIC DOCUMENTS  
WASHINGTON 25, D. C.

OFFICIAL BUSINESS

PENALTY FOR PRIVATE USE TO AVOID  
PAYMENT OF POSTAGE, \$300  
(GPO)

children

®

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Published  
6 times  
annually  
by the

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Marion B. Folsom, *Secretary*

SOCIAL SECURITY ADMINISTRATION • CHILDREN'S BUREAU

Charles Schottland, *Commissioner*

• Martha M. Eliot, M. D., *Chief*